Acton Nursing Services

Five Year Trend Analysis

Fiscal Years 2010-2014

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I. PURPOSE OF THE REPORT

Acton Nursing Services (ANS) has provided high quality home health, public health, and other community services to Acton residents for over 90 years. In the last nine decades, ANS has responded and adapted to unprecedented national economic crises, communicable disease outbreaks, significant demographic changes, dramatic shifts in payment for care, and ever increasing federal, state, and local regulations while still continuing its mission of providing valuable services to Acton residents. It is with this tenacity to its mission that ANS has survived, and in many years, thrived. In 2014, ANS is yet again at another crossroads to find a way to adapt to unparalleled changes in the United States' (US) health care system.

In the last five years, all certified home health agencies have seen shrinking reimbursement while at the same time have had increasing costs of providing care. Greater demands from new federal regulations and competition for patients with recent formation of Accountable Care Organizations (ACO) and other integrated health networks have destabilized the home health sector. The National Association for Home Care surveyed all certified home health agencies in 2013 and reported that by 2020, sixty-four percent (64%) of all US certified home health agencies will have operating deficits with predictions that twenty percent (20%) of US certified agencies will close in the next two years. These financial deficits have spurred significant merger and acquisition activity, particularly in Massachusetts with its heavy penetration of managed care compounding deficits.

In response to these forecasts, at its 2013 fall meeting the Board of Selectmen strategically charged the ANS leadership to begin exploring partnering with another certified agency to provide at-home services. HMS Healthcare Management Solutions, Inc. (HMS) was hired to facilitate those discussions with Parmenter Community Health Care (Parmenter), a local, independent nonprofit provider of visiting nurses/rehabilitation care/palliative care, hospice in the home and hospice residence care. After several meetings, specific terms of an agreement are currently being negotiated.

In addition to exploring a potential partnership, the Board of Selectmen requested a Five Year Trend Analysis of ANS to guide the Board's decisions about the future of ANS and potential service options. At the June 24, 2014 joint Board of Selectmen/Finance Committee meeting, members posed several questions that will be addressed in the RESPONSES TO QUESTIONS RAISED BY THE BOARD OF SELECTMEN/FINANCE COMMITTEE/PUBLIC section of this report. (See Section VIII)

This ANS Trend Analysis Report relied on data from the Agency and the Town Finance Department that included:

- Financial Data: budgets to actual, financial statements, profit/loss (P/L), balance sheets, cost reports, bad debt, charity care utilization by unduplicated count by discipline, commercial rates, Medicare Prospective Payment System (PPS) metrics, accounts receivable reports, payroll data by employee by employee type, productivity reports by employee and contractors;
- Home Health Patient Data: referrals, admissions by town, unduplicated counts, visits by payer by discipline by employee by town; and

- Public Health Data: employee hours by activity type with estimates of unduplicated patient counts.

Financial data was provided from four sources: 2010 – 2014 ANS software reports from HealthWyse, HealthCareFirst, Town Financial statements, and Medicare Cost Reports. Audited financial statements did not always tie to the software reports, but the discrepancies were not significant for the purposes of trending major changes in revenue and expenses and available software reports gave important data about referrals and utilization. Financial data for 2014 was not finalized in time for this report, but estimates of revenue and expenses were obtained primarily for noting the major shifts in referrals and revenue. Key operations and finance data are presented in the body of the report with additional tables referenced in the Appendices.

Home Health patient data for referrals, admissions, and visits were pulled from 2 software system reports and unduplicated patient counts from the Medicare Cost Reports 2010 – 2013 (2014 not submitted as of this report).

The analysis is based on the Agency's actual performance as compared to industry benchmark standards for the last five (5) fiscal years. Conclusions and recommendations within this report take into consideration health care and home health sector trends observed with the passage of the Patient Protection and Affordable Care Act, commonly called "Obamacare" or the Affordable Care Act (ACA). Centers for Medicare & Medicaid Services Innovations (CMMI) awards for Massachusetts are listed in the Appendices to demonstrate the scope of health care reform in the Greater Boston area impacting ANS.

Section II of the report takes a close look at the background factors impacting ANS today.
Section III focuses on key operations metrics.
Section IV describes the financial status of ANS.
Section V summarizes several potential options for ANS in a decision matrix format and introduces the concept of a Navigator Program as the town implements the 2020 Plan.
Section VI summarizes the conclusions of the report
Section VII gives HMS's recommendation on which option ANS should pursue to ensure quality cost-effective nursing and public health services to the residents of Acton in the future.
Section VIII is devoted to responding to the questions posed by the Board of Selectmen and Finance Committee members.

II. BACKGROUND

As ANS enters its ninety-second (92) year of continuous operations, there are unprecedented changes in the US health care system. These changes are exerting increased pressures on small and medium sized agencies to compete for market share and to remain in compliance with regulations for Medicare certification and billing privileges. Here are some of today's driving factors in health care:

Health Systems, Accountable Care Organizations and Hospital Trends:

Health Systems and Hospitals are creating mega-alliances and preferred provider networks to counter shrinking margins, increasing cost pressure and pricing issues while ACOs are moving from policy to implementing the practical side of accountable care. These organizations across the US share five common challenges:

- Declines in operating margins;
- Declines in Medicare reimbursement;
- Managing the impact of Medicaid expansions;
- Increased pressures from private payers; and
- Non-hospital growth over the next couple years.

To address the challenges listed above, Health Systems, Hospitals and ACOs are shifting their core businesses from a hospital-centric business model to a population-based, community-centric model. This trend increases the need for integrated clinical care management models enhanced and supported by technological advances. Core business and clinical models are affected in six key areas:

- **Reimbursement and Quality:** Moving from paying for the volume of services provided to paying for the outcome/value of care managed and delivered;
- **Care Management Methodologies:** The Affordable Care Act is shifting payment reform and care management from the individual to population health management models;
- **Transparency and Pricing:** Empowering consumers with greater choice and knowledge of cost and quality of providers;
- **Care Integration Beyond Four Walls:** Requiring new care integration across the care continuum including, but not limited to, such providers as the physician, hospital, outpatient facility, long term care provider, home health care and hospice agency;
- **Core Care Models Changes:** Shifting from illness to wellness and disease prevention care; and
- **Shifting Volume From Inpatient To Outpatient:** Studies show a broad-based transition underway from an inpatient-focused to an outpatient-focused health care system. A new study underpins the current impact of markets in Boston, Newark and Indianapolis experiencing inpatient volume and decreases across most age groups and service lines. Hospitals in the nine-county Eastern Massachusetts area (population 5 million) saw inpatient utilization decline 5 percent. Declines occurred among all age groups, with the greatest declines among ages 65 and older (10 percent) and ages 0-17 (8 percent). Declines occurred across almost all service lines, with the greatest declines seen in cardiovascular care (14 percent), pediatric care (8 percent), and cancer care (6 percent).

Future Reimbursement Trends and Concerns:

The Affordable Care Act includes a variety of payment reforms, especially in the Medicare program, which were meant to control costs and improve care. These reforms are targeted to promote new reimbursement methodologies as alternatives to the existing fee-for-service system. Instead of payments being based on the volume and price of the items and services provided to patients, these alternative methods of reimbursement create incentives to encourage preventive care and better care coordination, especially for patients with chronic illnesses. These new forms of payment will focus on methods that promote the triple aim of

health care as adopted by the Centers for Medicare & Medicaid Services (CMS) which includes: improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of healthcare. In addition, federal, state and commercial payers will continue to decrease the existing reimbursement of providers in order to slow spending on health care and promote the newer payment forms. Providers can expect to experience the following:

- Medicare reimbursement cuts while at the same time audits and penalties increase;
- Medicaid expansion with minimal and/or inadequate reimbursement;
- Payer spending on elderly projected to decline;
- Bundled post-acute payments (fixed amounts of payment to providers for a bundle of services provided to a patient during a set period of time) for agencies contracted with the episode initiators (hospitals, long term care providers, etc.);
- ACO (groups of health care providers who agree to share responsibility and financial risk for managing a population of patients) preferred provider networks with potential risk-based payment for services rendered; and
- Patient-centered medical homes which are redesigned primary care practices that manage and coordinate the care of multiple service providers with an emphasis on preventive care, patient education and chronic care disease management. Participation with these physician practices may be limited to preferred providers.

Population Longitudinal Management Trend:

The healthcare delivery system is shifting from managing illness to wellness and prevention. Government and private payers are moving rapidly to a value-based risk payment that includes rewards and penalties for system-wide performance on population-based metrics, such as inpatient readmission rates and preventative care for chronic conditions. The impact will affect stakeholders to "un-silo" the care continuum in a number of ways:

- Reduce the cost of care and duplication of services across the continuum;
- Increase efficiencies of scale;
- Develop cost containment strategies to keep patients out of the hospital;
- Expand care/case management horizontally integrating inpatient, outpatient, rehabilitation, **home and preventative care** to achieve performance benchmarks;
- Integrate information technology driven by data analytics, electronic health records, predictive models, risk management and evidence-based pathways;
- Develop better patient engagement and compliance after hospital discharge; and
- Implement clinical integration across the continuum with agreements on certain clinical standards and protocols for a given patient population Healthcare spending will increase if providers fail to manage high-risk patients. Care management programs will be critical to reduce healthcare spending.

Greater Information Technology and Technology Investment Trends:

The banking and airline industries transformation resulted in heavily optimizing technology, reducing labor costs and transaction standardization. This will ultimately be how the health care industry transforms as well. Some of the exciting, albeit, potentially costly technology trends affecting providers include:

- Electronic Health Records and ensuring "meaningful use" of this technology;

- mHealth which is the use of mobile-based or mobile-enhanced solutions for the use of health management;
- Telemedicine/Telehealth to connect patients and caregivers in a cost effective, scalable and patient friendly manner;
- Data Analytics being used to gain valuable insights into ways to become more cost-effective and accelerate patient care;
- Predictive Modeling on comprehensive health data to enable accurate prognosis and treatment decisions;
- Clinical Informatics to deliver health care services;
- Virtual Health/E-visits to facilitate a virtual exchange of medical information with a health care provider; and
- Data security enhancements to ensure patient privacy and confidentiality and adherence to regulations.

The Value Equation – Clinical, Financial and Operational Integrated Network Trends:

Case/Care managed coordination across the continuum are likely to include the following:

- Tracking/following patients from one care setting to another;
- "The right care at the right time";
- Intervention-based care;
- Development of innovative clinical models to fill care gaps existing today;
- Enterprise-wide, evidence-based care protocols;
- Provider clinical performance, outcomes and utilizations of evidence-based care protocols;
- Longitudinal care management tracking;
- Technology-enabled care management systems;
- Performance metrics to support operational, clinical and financial goals. Reengineered care delivery across the continuum to succeed in value-based, population health management models;
- Leveraged resources across the continuum to gain cost efficiencies; and
- Care continuum partnerships that support aligned operational, financial and clinical goals. The new value equation between acute and post-acute supports clinical integration infrastructures and networks. It offers providers the opportunity to coordinate patient interventions, manage quality across the continuum of care, move toward population health management and pursue true value-based contracting.
    - Payment reform: e.g., Post Acute Bundling Initiatives (BPCI);
    - Merger/Acquisitions; and
    - Large networks squeezing smaller agencies out.

Massachusetts Health Care System Trends and Forecasts

In response to US health care reform, the Commonwealth has also implemented systematic changes to health care delivery affecting home health agencies.

- Massachusetts (MA) has achieved the highest rates of insurance coverage in the US with only 242,000 residents uninsured in 2010;

- With Massachusetts deciding to implement the Medicaid expansion under ACA, nearly six in ten (57%) uninsured nonelderly people in the state became eligible for financial assistance to gain coverage through either Medicaid or the Marketplaces;
- Between December 2013 and March of this year, when the federal government was urging people to enroll, the number of Massachusetts residents who signed up for health coverage increased by more than 215,000. If that number holds, the percentage of Massachusetts residents who do not have coverage will have dropped to less than 1 percent;
- Health care spending in MA increased from twenty percent (20%) in FY2000 to thirty-nine percent (39%) in FY2013 driven largely by enrollment growth; if the health care spending continues at this rate, the FY2020 budget could be fifty percent (50%);
- Subsidized and employee health coverage programs account for forty percent (40%) of the budget;
- Since these historic rates of increases are unsustainable for governments, businesses, and families, cost containment initiatives will be implemented such as payment reform and integrated systems of care;
- Health Care Cost Containment Legislation passed in August 2012 requires state programs to use new payment methods, certifies ACOs and Patient-Centered Medical Homes, and commits $57 million over four years to invest in *community-based prevention, public health, and wellness efforts* to reduce the cost of preventable chronic diseases (obesity, diabetes, asthma). Funding will be administered through *competitive grants to municipalities,* community organizations, health care plans and providers. The Department of Public Health (DPH) will develop a model wellness guide and a wellness tax credit for small businesses;
- Under ACA, all Massachusetts residents under one hundred thirty-three percent (133%) of the federal poverty level are eligible for MassHealth if they are citizens or *qualified aliens*. *Aliens with Special Status with incomes of three hundred percent (300%) of the poverty level may be eligible for premium assistance;*
- MassHealth will continue to support employees of small businesses through a pilot program offering premium assistance;
- MassHealth will implement an innovative payment system that combines a Comprehensive Primary Care Payment with a shared savings/risk arrangement and quality incentives. A *capitated risk adjusted payment* for certified medical homes will be offered with the potential for out-patient behavioral health services
- Innovations in primary care delivery include improving access through phone and email services, expanding the care team to include community health workers and using group or family visits;
- The Patient-Centered Medical Home model (PCMH)(See definition of PCMH in Appendix F) supports fundamental changes in primary care service delivery and payment reforms to address fragmented care, increases in cost of chronic disease, and a growing shortage of primary care providers. PCMHs model is designed to coordinate care throughout the continuum of care from hospitals, sub-acute, long term care facilities, to the community or home through interdisciplinary teams. The

Commonwealth has set a goal for all primary care practices to become PCMHs by 2015; and

- MassHealth intends to reduce nursing home rates by 0.03 percent below FY2013 estimated spending levels. This is consistent with policies to shift members out of nursing homes *into the community.*

Competition for Patients

In the last five (5) years, the most dramatic trend for ANS has been the loss of patient volumes. Competition for patients has increased not with new competitors as much as bigger competitors aligned with larger networks that are capturing market share. Here are some of these competitive forces:

- Larger networks of hospital-based and ACO contracted agencies taking more patients without regard to patient choice;
- Medical Homes doing home care developing outreach to patient homes;
- Independence at Home demonstrations with physicians making home visits;
- Physician-owned home health agencies;
- Long term care facilities buying home health agencies to bundle and control post-acute care and state rebalancing initiatives to keep patients out of nursing homes and in the community; and
- Emergency Medical Services (EMS) proposing to provide home care as an expanded service (see Appendix H for summary of US and MA legislative activity).

Home Health Sector Opportunities and Threats

While forecasters are estimating a near doubling of traditional home health expenditures in the next ten years, largely due to the aging of America (12.4% Medicare beneficiaries in 2000 to 19.6% by 2030) and the preference of baby-boomers to receive care at home, traditional home care service delivery models and payment are in a period of unprecedented change and must determine how to reduce overall costs of care while implementing new core service lines and enhancing informational technology solutions. Home Health Care delivery models and payment reforms will happen. Here are some of the changes experts are predicting for home health agencies:

- Shared savings programs only for those agencies that participate (see Bundled Payment Care Initiatives (BPCI) in Appendix E);
- Patient Centered Medical Homes with the primary care physician (and physician extenders such as physician assistants and nurse practitioners (APRN) at the center of the "home" monitoring care by all providers *and family members;*
- Rewarding fewer hospitalizations and emergency room visits by partnering only with agencies that can demonstrate targeted readmission goals and can electronically share data;
- Seeking home health agencies that have sophisticated chronic disease management programs; telehealth to monitor symptoms remotely that are transmitted to primary care providers; mobile software applications with connectivity to all providers feeding data continuously to a centralized database to control costs; drug reconciliation that could include pharmacists doing home visits; or APRNs on staff at the agency that make critical post-acute home visits to avoid readmissions to the hospital;

- Expansion of Medicaid Home and Community Based Services with waivers to pay for homemakers, companions, meals, transportation, emergency response systems and other services not covered by state Medicaid plans;
- Expansion of managed Medicare, currently at thirty percent (30%) market share, with rewards for agencies that outperform other agencies and preferred relationships with those agencies;
- Threat: Medicare payment cuts with second year of "Rebasing" the PPS system. All 153 Home Health Resource Groups have been recalibrated plus a two percent (2%) sequester cut expected in April 2015;
- Threat: home health penalties for readmissions to the hospital within thirty (30) days;
- Threat: bundled post-acute care payment for skilled nursing and home care for agencies not included in the bundled networks; and
- Threat: fraud and abuse audits that fall on good agencies

History of CMS Home Health Mandates from 2010 – 2014

All certified home health agencies must comply with all mandates regardless of size and resources to accomplish these mandates. ANS has kept pace with these mandates but with enterprise funding increases to support the shortfalls. Here is a sample of the mandates from 2010 – 2014 and the associated cost implications to comply:

- Change Request (CR) 6757: Coding patient transfers (software upgrade and training);
- CR 6911: Enhancements to consolidated billing under PPS for medical supplies (additional supplies that are bundled under Medicare PPS without additional reimbursement);
- CR 6982: Outcome and Assessment Information Set (OASIS) submission requirements (2% reduction in base rate for failure to comply);
- CR 7114: Payment penalties for failure to submit OASIS (full payment denial);
- CR7182: G coding nursing and therapy services (software upgrade and training);
- CR 7256 New fraud investigations and audits by the Office of the Inspector General (OIG) including a New England audit conducted in 2012;
- CR 7329: Face to Face certification clarifications (67% medical review denials to date in US)(National Association for Home Care filed suit in July 2014 challenging CMS's interpretation and implementation of the F2F requirements);
- CR 7374: Rehabilitation reassessment requirements (extensive training for documentation requirements with denial for failure to document timely);
- CR 7396: Timely claims filing requirements (shortened time limit or full denial);
- CR 7338: Billing manual changes (software changes and training);
- CR 7323: New Advance Beneficiary Notices (printing expenses and training);
- CR 7704: International Statistical Classification of Diseases and Related Health Problems (ICD10) mandate effective 10/1/14 later postponed until 10/1/15 (massive software changes and training expected to impact entire health care system);
- CR 7890: Physician Enrollment in Provider Enrollment, Chain and Ownership System (PECOS) (monitoring and payment penalties for non-enrolled physicians);
- CR 8139: Common Working File crossover (delayed payments for Medicare Part A to Part B crossover);
- CR 8404: new Advance Beneficiary Home Health Notice (printing and training costs);

- CR 8441: New requirements for physician certifications (Recovery Audit Contractors and Zone Program Integrity Contractors stepped up medical review; Center for Medicare Advocacy filed a lawsuit against CMS in June 2014 challenging arbitrary and capricious medical reviews (98% denial rate) at the two lower levels of appeal;
- CR 8444: New homebound definition (training and documentation);
- CR 8380: Low Utilization Payment Adjustment add-on (software upgrade); and
- CR 8458: Jimmo lawsuit settlement and changes in home health coverage (training and documentation).

New Home Health Mandates for CY2015

In addition to maintaining compliance with all federal, state, and local regulations, ANS will face more regulatory pressures in 2015. Some of these new regulations are listed below with related cost implications to comply:

- Medicare PPS Proposed rates effective 1/1/15 with a full recalibration of all 153 Home Health Resource Groups (potential financial impact of three – seven percent depending on the HHRG coded by ANS);
- OASIS C1 ICD9 1/1/15 (software upgrade and extensive training);
- Federal emergency preparedness regulations 1/1/15 (extensive training and documentation); and
- OASIS C1 ICD10 10/1/15 (massive software upgrades, billing requirements and cash flow impact unknown; extensive training and front end support needed to secure all seven digits for coding)

III. ACTON NURSING SERVICE OPERATIONS TRENDS

Operational trends for both home health care and public health services were analyzed separately to provide data for the Town Board of Selectmen and other stakeholders to determine the best future options for Acton residents.

To help readers of this report, the Social Security Act of 1966 defines home health services as "…items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical or occupational therapy or speech-language pathology services;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, and a covered osteoporosis drug, but excluding other drugs and

biologicals) and durable medical equipment while under such a plan…" (Social Security Act 1966)

These home health care services are reimbursable through governmental payers such as Medicare and Medicaid and most often through various commercial insurers. Since there are limits in the coverage of the home health care benefits, many individuals will pay privately for supplemental services. ANS is reimbursed for services that qualify as home health care visits given the definition above, but is not reimbursed for public health services such as blood pressure or podiatric clinics (see Table 2 below). These public health activities are most often an administrative cost to ANS.

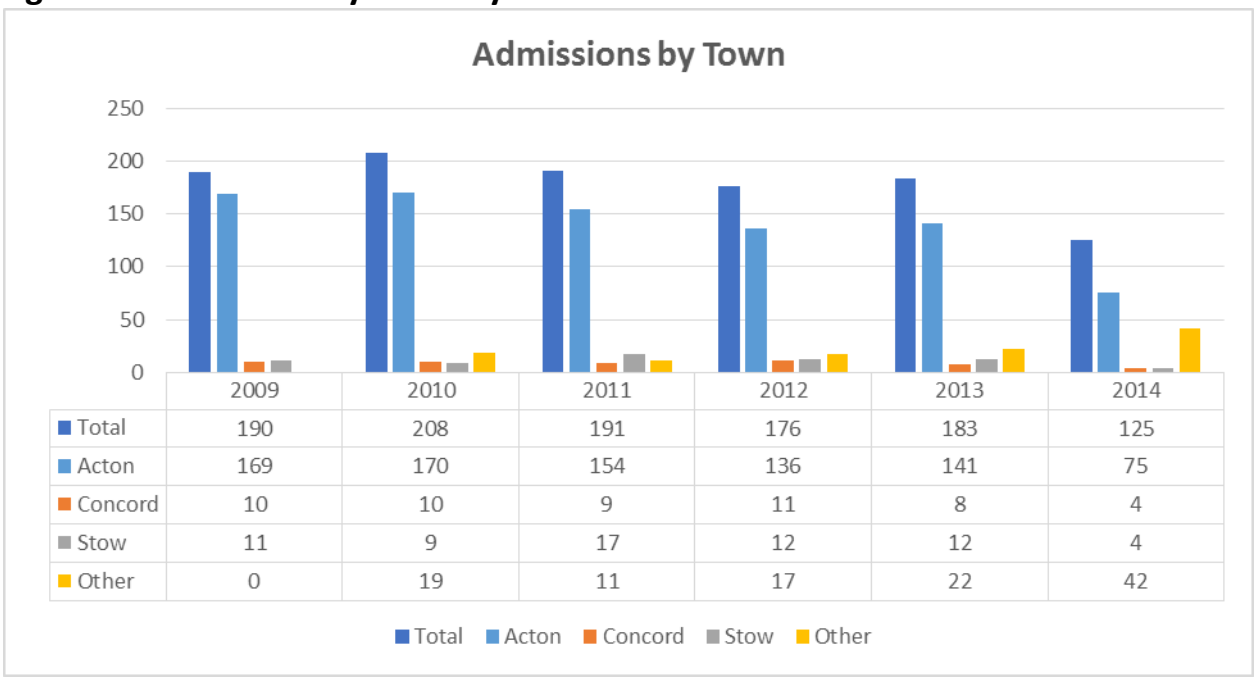
Below are the trends of ANS in home health services provided from Fiscal Years (FY) 2009 – 2014

ANS Home Health Data and Trends

ANS provides home health care services to the residents in nine (9) towns (Acton, Boxborough, Brighton, Carlisle, Concord, Littleton, Maynard, Peabody, and Stow). Figure 1 shows the total number of admissions with billable visits by fiscal year. Since FY2012, admissions have been steadily decreasing. There was a significant drop of 32% in total admissions in FY2014 as compared to FY2013. This decline in FY2014 total admissions had a negative effect on ANS revenue.

Figure 1 also shows the percentage of admissions by town. In FY 2009 through 2011, admissions from Acton residents accounted for 89% to 81% of the total admissions, respectively. For FY2012 and 2013, that percentage dropped to 77%. In FY2014, the number of admissions from Acton resident accounted for only 60% of all admissions.

Figure 1: Admissions by Town by Fiscal Year



	2009	2010	2011	2012	2013	2014
Total	190	208	191	176	183	125
Acton	169	170	154	136	141	75
Concord	10	10	9	11	8	4
Stow	11	9	17	12	12	4
Other	0	19	11	17	22	42

Source: HealthWyse Reports 2009 -2013; Healthcare First 2014

While the admissions (and the percentage) of Acton residents show a steady decline over the last several years, the number of home health visits delivered by various ANS staff also has changed. Table 1 is a description of home health visits by discipline by year.

The data show a trending toward lower total visits and a shift in the type of discipline utilized from therapy to nursing. In fiscal year 2014, there is a significant decline in total visits and rehabilitation visits. This negatively affects Medicare reimbursement as Medicare payments are tied to combined therapy (physical, occupational and speech therapy) visit volumes and utilization. Even though nursing visits increased in FY14 from FY13, nursing visits do not affect Medicare reimbursement in the same advantageous manner as do the therapy visits.

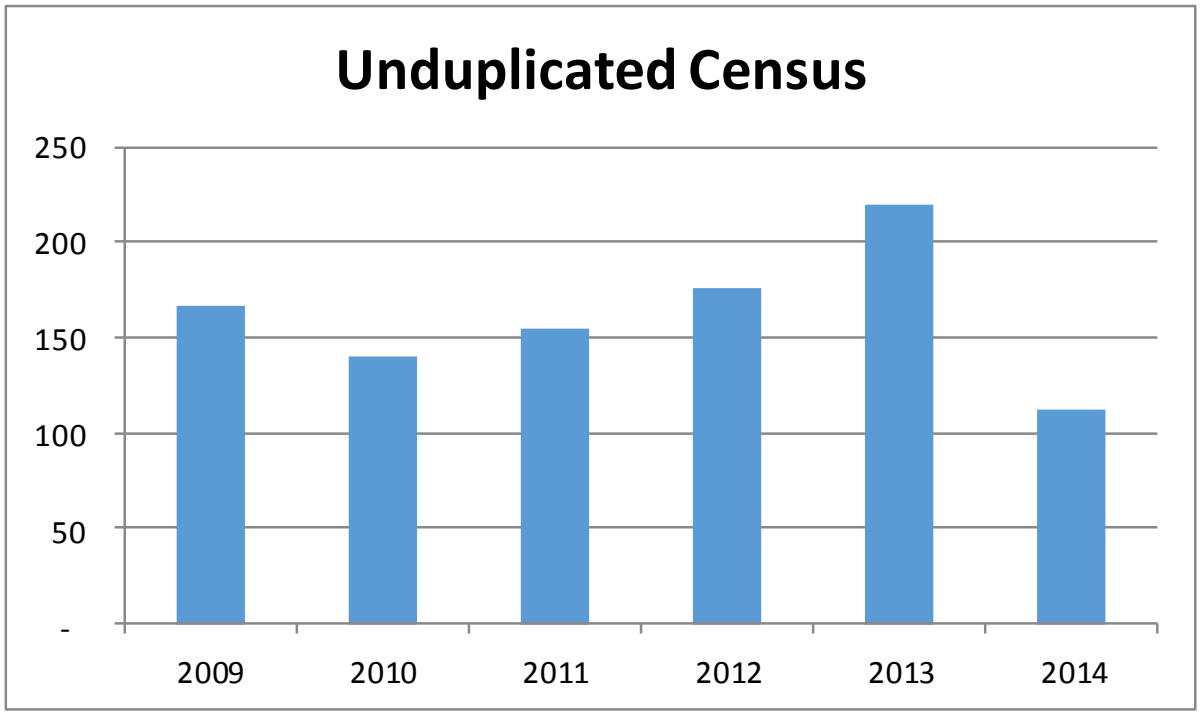
Table 1: Home Health Care Visits by Discipline by Fiscal Year

Visits by Discipline	2009	2010	2011	2012	2013	2014
Skilled Nursing	1,447	1,839	1,623	1,484	1,665	1,966
Physical Therapy	1,203	1,360	1,158	1,188	1,137	419
Occupational Therapy	117	74	70	69	122	47
Speech Therapy	10	6	0	11	35	0
Medical Social Work	0	1	5	0	0	0
Home Health Aide	2,546	2,538	2,190	1,980	2,066	2,183
Total Visits	**5,323**	**5,818**	**5,046**	**4,732**	**5,025**	**4,615**

Source: HealthWyse Reports 2009 -2013; Healthcare First 2014; Cost Reports

While admission and visit data showed steadily decreasing trends, the unduplicated patient census, as shown in Figure 2 below, indicated a different trend. Until FY2014, the unduplicated patient census showed a steady increase in volume. In FY2014, the unduplicated patient census showed a significant drop in volume of 49% from FY2013 (112 unduplicated census versus 219 unduplicated census, respectively).

Figure 2:



Source: HealthWyse Reports 2009 -2013; Healthcare First 2014

These data point to a current trend throughout the home health care industry. With increased market competition and ACA promoted networks, smaller and mid-sized agencies are struggling to maintain a steady flow of admissions and patient census.

ANS Public Health Data Trends

In addition to home health services, the ANS Public Health Program has included mandated communicable disease prevention; communicable disease surveillance and investigation; outreach, case-finding, and control efforts including influenza/H1N1 vaccination programs; chronic disease screenings; community wellness talks; and interdepartmental Safety Net Program meetings for residents at risk, including home safety visits. ANS has maintained office hours for walk-ins and takes calls for home evaluations from the Acton Police and Fire Departments. These activities are budgeted distinctly since 2012 and direct costs have been controlled over the last five years. Currently, all home health staff provides assistance with public health and community screenings with time allocations to these activities. Only Acton residents receive these public health and health promotion services. The agency software does not "admit" health promotion clients and reports of unduplicated residents served are not available. The podiatry clinic estimates 106 Acton residents have received podiatric services. Council on Aging Wellness clinics are scheduled two times per month for two hours; Windsor Green once a month; and Robbins Brook Assisted Living once a month. Office hours are flexible and three registered nurses (RN) staff wellness checks in the ANS office.

Table 2 below summarizes public health activities and hours spent from FY2011 – 2014. The data show that selected activities remain a strong focus of ANS with activity levels that reflect public health needs in any given year.

Table 2: Public Health Activity by Service

Public Health Activities	2011	2012	2013	2014
TB Testing	26	15	6	11
Blood Pressure Checks	402	595	806	798
Podiatry Clinic	381	355	285	289
Influenza Vaccinations	1,326	845	1,690	1,006
Other Vaccinations	23	17	27	17
Total	**2,158**	**1,827**	**2,814**	**2,121**
Public Health Nursing Hours				
Acton (General Fund)	1,389	1,693	2,408	2,286
Stow (Billable Contract)	156	156	208	208
Total Public Health Nursing Hours	**1,545**	**1,849**	**2,616**	**2,494**

Source: Agency Annual Report

ANS Daily Operational Activities

As part of the home health care trend analysis, the certified agency's daily operations functions were evaluated to determine how the agency has performed compared to national standards. Those standards are recognized as mandates by CMS' Medicare Conditions of Participation regulations and industry reports of the best run agencies. Each functional area related to the revenue cycle was reviewed (see Appendix C for standard revenue cycle management functions).

Intake/Referrals

The Administrator and Clinical Manager with direct nursing care duties take all referrals as mandated by regulations. Trends with top referral sources over the last six (6) years indicate that Emerson Hospital continued to be the primary referral source with the loss of other referrals to competitors as shown in Table 3. The top seven (7) known referral sources are listed from FY2009 – 2014:

Table 3: Major Referral Sources by Fiscal Year

Referral Source	2009	2010	2011	2012	2013	2014
Emerson Hospital	30	32	40	33	35	32
Minute Man	23	4	8	10	6	4
Dr Knights	21	26	10	10	3	0
Emerson TCU	18	8	11	16	17	13
Lahey Clinic	17	19	24	10	9	3
Concord HC Center	4	4	3	9	6	3
Lifecare Center(s)	11	16	11	15	16	8
Unknown*						37*
Total Referrals	**202**	**210**	**191**	**176**	**183**	**132**

Source: HealthWyse reports 2009 – 2013; Healthcare First 2014

*This large number of unknown referral sources requires further analysis. In 2014, ANS converted to a new software system which may have influenced this indicator.

Total referrals in 2014 were 28% fewer than 2013 and 25% fewer than 2012, compounding the loss of revenue with fewer Medicare referrals from each of the major referral sources. It is not uncommon to see competitors give non-Medicare referrals to their competition and keep the Medicare patients due to the better reimbursement rates from Medicare for home health care versus other payers.

Assignment of staff

Referrals are then assigned and a start of care visit is made within 24 hours (99% CMS score, which exceeds CMS' benchmark and the standard for admission within 48 hours). All new patient referrals must be admitted by a registered nurse unless the patient only needs physical therapy care.

Admissions

Per CMS regulations, ANS RNs admit patients within 24 hours of receiving the referral completing documentation for the Outcome and Assessment Information Set (OASIS) review and the International Classification of Disease, version 9 (ICD9) coding. Plan of Care physician orders are completed and professional visits and home health aide hours scheduled pursuant to physician orders. Weekly schedules are managed with productivity standards reviewed daily to industry standards. As of 2011, per visit per diem staff was added to control expenses and maintain capacity for new referrals. Productivity was maintained at 6 visits per day for salaried employees. These are consistent with home health industry benchmarks (See Table 6 below)

Medicare PPS Utilization Management

Medicare's Prospective Payment System (PPS) is based on fixed payments for 60-day episodes. Management of utilization is critical to running a successful home health program where commercial rates fall below unit costs (see commercial rates and unit costs in the financial section). Profits realized in the Medicare population offset the losses on the commercial population; therefore, maintaining a Medicare payer mix (net revenue) and industry standards for Medicare utilization are almost the only ways to achieve financial viability (see payer mix analysis in the financial section, Figue3. Medicare benchmark metrics are used to achieve budgeted goals for Medicare revenue. Some of those metrics are:

- Visits per episode by discipline
- Casemix weight
- Percentage of Low Payment Utilization Adjustments (LUPA)
- Rehabilitation visits per episode by tier
- Profit/Loss by episode
- Percentage of downcodes

The information in Tables 4 reports the changes in national Medicare utilization data from the years of 2002 to 2012 while Table 5 shows the Medicare utilization data of selected ANS indicators.

Table 4: US Medicare Home Health Utilization Metrics 2002 – 2012

Metric by year	2002	2011	2012
Number of Beneficiaries (in millions)	2.5	3.4	3.4
Percent of beneficiaries	7.2	9.6	9
Episodes (in millions)	4.1	6.8	6.7
Episodes per patient	1.6	2	2
Visits per episode	18.4	17.2	16.9
Visits per patient	31	34	33
Average payment per episode	**2,335**	**2,691**	**2,677**

Source: Data Book: Healthcare Spending and the Medicare Program/ June 2014

Table 5: ANS Medicare PPS Utilization Metrics 2010 – 2014

Metric by year	2010	2011	2012	2013	2014
Episodes per patient	3.8*	5.3*	4.1*	5.4*	1.27
Visits per episode	21	24	23	22.5	20
Average case mix weight	1.33	1.39	1.44	1.34	1.033
Average rehabilitation visits	6.7	7.1	7.6	6.1	1.74
Average payment per episode	**$3,193**	**$3,370**	**$3,336**	**$3,001**	**$2,874**

Source: HealthWyse reports 2010 – 2013; Healthcare First reports and AR reports 2014; Cost Reports
*3 patients on service over 3 years skewed episodes per patient

As described**,** ANS management of PPS utilization exceeded US and MA metrics for case mix, rehabilitation utilization, and average payment per episode for FY2009 - 2013. In FY2014, there was a thirty-six percent (34%) drop in case mix weight with a significant drop in rehabilitation utilization that drives the case mix weight and ultimately the reimbursement (4.2% drop in revenue per episode from the prior year). Visit costs exceeded US benchmarks all five (5) years for nursing and home health aide utilization due to some long term patients that also skewed visits per episode slightly reducing their margin on care. Overall, the Medicare utilization management was favorable and lessened the operating deficit.

<u>Admissions, OASIS review, Request for Anticipated Payment (RAP) submission, OASIS submission</u>
All Medicare patients are admitted using a standardized 100+-item data set called OASIS (Outcome Assessment and Information Set). Once the OASIS is completed, it must be reviewed for payment and quality reports. More agencies have moved toward certified OASIS and ICD9/10 coders to optimize reimbursement and compliance on federal audits. Smaller agencies either outsource this function or perform it in-house as does ANS. Following the validation of coding, billing for the RAP occurs resulting in a payment of sixty percent (60%) and (50% for subsequent episodes) of what is expected to be the full amount of reimbursement for services during the 60-day episode. Full payment is made at the completion of the episode and upon submission of a final bill. Importantly, successful OASIS submission to the Massachusetts state repository must occur prior to billing as a condition for payment. Failure to submit prior to billing was the subject of a New England Office of the Inspector General (OIG) audit in 2012. The results of that audit found that sixty-five percent (65%) of claims submitted did not meet these requirements and were subject to denial and financial recoveries. Although ANS was not selected for this audit, future audits will be conducted with denial for all claims without

acceptable OASIS transmissions prior to billing. This remains an area of potential financial exposure for all agencies.

In summary, OASIS drives both clinical and financial outcomes that require daily vigilance to be successful. ANS has managed OASIS processing at or above industry standards.

Patient Visit Assignments and Productivity Functions

Another key business metric for viable home health agencies is management of employee productivity at or above industry standards. Visit productivity per day must be closely monitored with reports of employee visits factored by hours worked per week and compensation (salaried, hourly, or per visit). US productivity standards in 2010 reported by the National Association for Home Care as shown in Table 6 were:

Table 6: National Productivity Benchmark, 2010

Staff Type	Visits per 8 hour day
RN	4.96
LPN	5.9
PT	5.17
OT	5.3
Social Work	**3.48**

Source: NAHC Benchmarks 2014

Following good industry practice**,** ANS closely monitors productivity on a daily basis focusing on fixed expense employees (salaried and guaranteed hourly), using per diem staff only when salaried and hourly employees are at or above productivity. Productivity expectations (six visits per day) are enforced above national standards. Both the Administrator and the Clinical Manager will make billable visits rather than use per diem staff. This is also true of home health aides and the receptionist (also a home care aide) who will make visits to avoid using per diem aides. It should be noted that the agency software does not calculate productivity (visits/day) to compare to the above benchmark; however, the daily operations oversight was described as consistent with industry practices to achieve cost effective management of staff.

Quality Management

As CMS moves toward value-based purchasing, quality outcomes and patient satisfaction scores will determine how agencies are chosen for larger network participation and how they are paid.

ANS' quality indicators out performed most agencies within the US and was recognized by Home Care Elite status in 2009 and 2011 (in top 25% of US certified agencies) and as being one of the top 500 agencies in 2012 and 2013. Publicly reported outcomes outpaced area competitors in seven of 22 outcomes and all five of the patient satisfaction scores. This is a remarkable achievement for a small agency. (See Appendix B for actual scores)

ANS was surveyed by MA Department of Public Health (DPH) for their recertification in 2007, 2009, 2012 with a deficiency-free survey in 2007, three standard deficiencies in 2009, and two standard deficiencies in 2012. An Office of Inspector General Report in 2008 stated that the average number of deficiencies cited was 5.7 demonstrating that ANS compliance exceeded US

benchmark. Following each survey with deficiencies, ANS implemented a Plan of Correction and the agency subsequently was considered to be in full compliance. CMS does not announce surveys, but it is highly likely the agency will again be surveyed in 2014 or 2015. It should also be noted that in July 2014 CMS instituted new Civil Monetary Penalties for Condition Level deficiencies (higher level deficiencies), therefore, maintaining compliance with Medicare Conditions of Participation avoids these potential penalties.

Human Resources Management

The management of the human resources within a home health organization is critical to its success and influences its clinical and financial outcomes. The current roster of active salaried or hourly employees is 6.46 FTEs. These employees have an average of 7.1 years of service with favorable performance according to industry standards for clinical care and documentation.

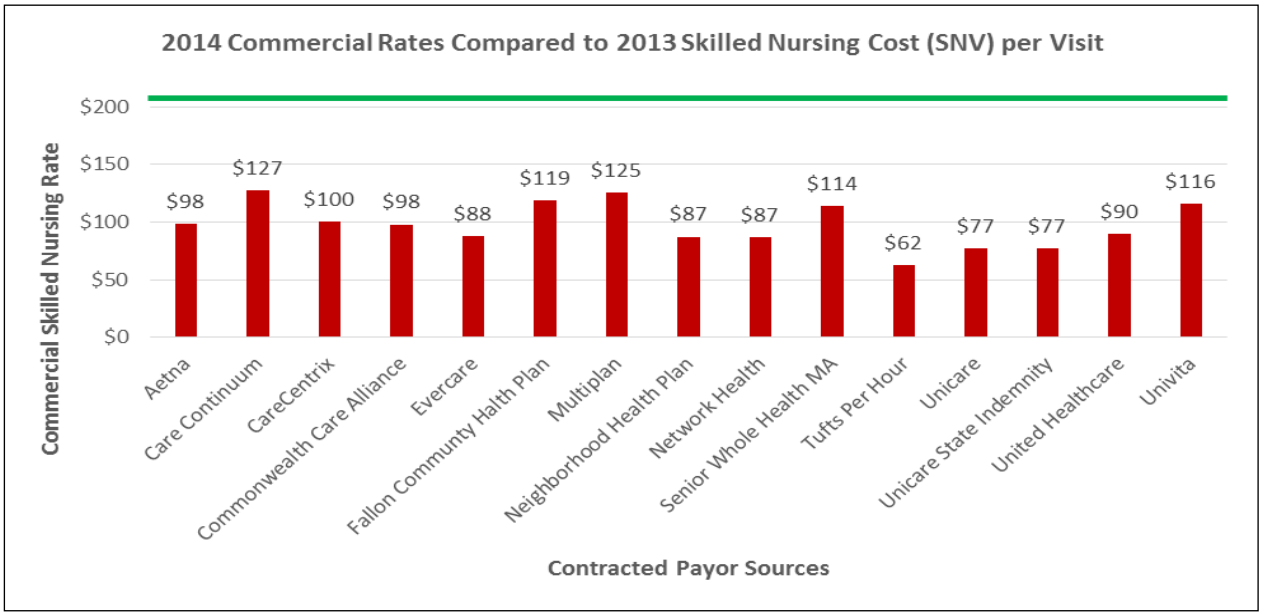
At ANS, all human resource management is performed by the Administrator with support from the Town Human Resource (HR) Department. All new benefited employees receive Town orientation and all home health and public health orientation is done by the Administrator. Pre-hire background checks and certification searches are done by Town HR while all other HR management functions, such as references checks, interviewing, offer letters, performance reviews, progressive discipline, exit interviews and Workers' Compensation first report of injury, are completed by the Administrator. As noted in the productivity reports, the Administrator manages the workforce closely avoiding over time and controlling labor costs.

Contract Management

There are 14 non-Medicare payers negotiated by VNA of New England (VNANE) to secure group rates that smaller agencies cannot negotiate. The VNANE annual dues are $7,650 for this contracting service. Two contracts are negotiated by ANS and not subject to VNANE group rates. Over the last 5 years, commercial and contract rates have remained flat with the exception of a small increase in Aetna rates. Rates for all disciplines are well below cost per visit as reported on the Medicare Cost Report. As commercial referrals have increased and profitable Medicare referrals have decreased, the margin on care has been negatively impacted.

Figure 3 below shows the skilled nursing commercial rates in 2014 compared to the skilled nursing cost per visit (green line):

Figure 3: Commercial Reimbursement Rates versus Agency Cost per Visit



Source: Agency Reports

Marketing

Marketing home health services requires a comprehensive and aggressive approach to securing new referrals and maintaining existing referral sources. Marketing plans include branding strategies and promotional efforts to keep an agency visible and a preferred provider for referral sources by promoting certain Agency statistics such as outcome and patient satisfaction data. Promotional strategies now include social media and other digital marketing along with traditional paper collaterals for distribution to the community. Sales teams maintain constant contact with referral sources to build relationships. Sales staff works at making the referral process as effortless as possible for the referral source, tracking all potential referral sources and following up on a regular basis to promote a positive working relationship and loyalty.

In the last two years, ANS has budgeted $20,000 for marketing with a complete rebranding of the agency in 2012. No sales force staff is used and tracking referrals is done manually. Vendor contracts for marketing cover advertising, collaterals, website development, and Minuteman activities. Friends of Acton Nursing Service (FANS) assist with mass mailings each year to promote the agency. Without the same marketing and sales resources of the competition, ANS has relied on its reputation and promotional activities to secure referrals, but this was not sufficient to overcome the competitive market and impact of larger integrated networks taking referrals from ANS.

In the last three years, ANS has witnessed an erosion of referrals by larger competitors that employ sales force team members and by networks that pressure their physicians to refer patients to their own agencies. Referral volumes dropped by twenty-five percent (28%) in FY14 from FY13. Equally damaging, Emerson Hospital referred fewer Medicare patients in FY13 (45.7%) than FY11 (57%).

Information Technology

Information technology is a critical element in the operations of a successful home health agency. ANS has invested in information technology and maintained best practices for clinical documentation. ANS uses home health software for electronic patient care documentation, reporting, billing, and other CMS mandated functions. New employees are trained on the electronic health record and all employees receive training with every new Change Request regulatory mandate. It should be noted that the agency changed software programs beginning in FY2014 to decrease agency expenses. Hardware and network support is managed by the Town, but all software related functions are performed by the agency under the direction of the Administrator.

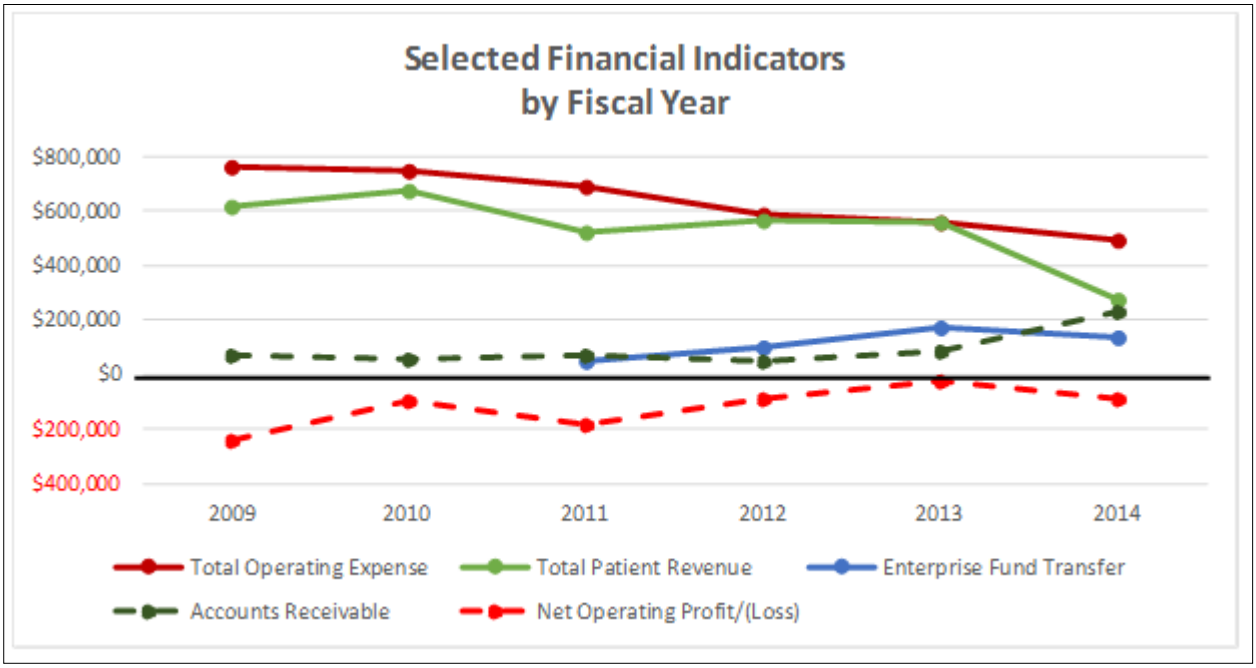
In the near future, all home health agencies will face enormous software changes and training demands due to new reimbursement models, as well as, to comply with new regulations that affect areas such as OASIS and the conversion from ICD9 to ICD10 slated for 2015. With the need to demonstrate successful outcomes and manage new care models such as Accountable Care Organizations and Patient-Centered Medical Homes, increased investment is expected to be a future cost factor.

IV. FINANCIAL TRENDS

The financial viability of a certified home health agency rests on securing and managing referral volumes and controlling cost of care. In general, agencies with an average daily census consistently above 75 have the critical mass to manage market changes in referral patterns, payer mix, and higher costs to hire and retain quality employees. In the last five years, ANS has experienced declining referrals at a rapid rate coupled with declining Medicare reimbursement and commercial rates far below unit costs. As Medicare volumes decreased and commercial volumes increased, operating deficits increased. Direct care costs and overhead continued to exceed revenues creating operating deficits offset by Town enterprise funds. Faced with these types of challenges, smaller agencies such as ANS cannot reduce fixed salary costs sufficiently and remain compliant with federal regulations for Medicare certification.

Figure 4 below depicts the trends in revenue, expenses, net operations, and enterprise fund transfers. As patient revenues declined over the last several years, operating expenses were reduced. Not until FY2014 was the decline in revenues so sharp that reductions in expenses could not be made without jeopardizing certification status. The drop in patient revenue was driven by a 35% loss of referrals from 2010 to 2014 and particularly a drop in Medicare referrals. Operating deficits for each of the last four years required enterprise funds to supplement agency operational expenses. From an accounts receivable (A/R) standpoint, the large increase in outstanding A/R in 2014 was due to a software vendor failure. This failure was identified and corrected to avoid Medicare denials, but Medicare payment was not recognized by the close of the fiscal year. This revenue will be captured in FY2015.

Figure 4:



Source: HealthWyse AR Reports 2009 – 2013; Healthcare First 2014; Municipal Budget Reports; Town Financials

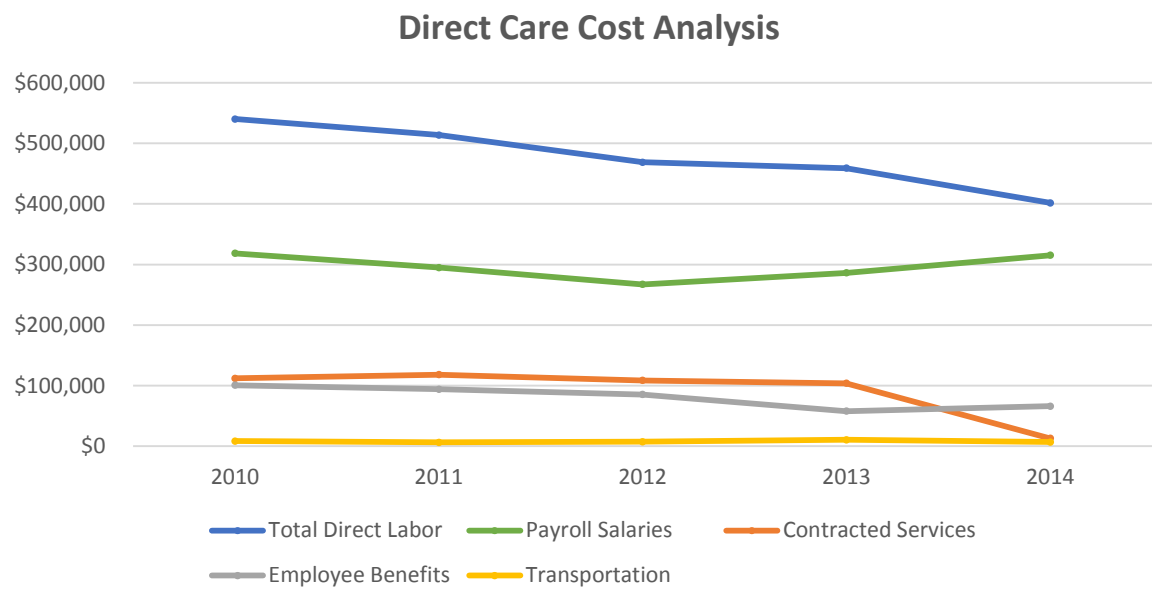
FINANCIAL INDICATOR	FY09	FY10	FY11	FY12	FY13	FY14
Accounts Receivable	68,293	52,006	66,918	45,999	85,989	232,487
Total Patient Revenue	619,279	675,386	624,002	564,117	557,158	273,617
Total Operating Expense	761,263	747,209	688,344	583,978	556,277	492,277
Net Profit/Loss	-246,370	-96,520	-184,413	-89,284	-26,542	-93,642
Enterprise Fund Transfer	-	-	50,000	100,000	175,000	135,000

Summary of Financial Trends

Based on the many reports reviewed and analyzed, the following is a condensed summary of observed trends:

ANS cost for total direct labor, direct labor, benefits, contracted labor and transportation is depicted in Figure 5. The data show a consistent lowering of expense for total labor cost over time. From FY2010 – 2012, the cost of payroll salaries and employee benefits declined to adjust for a decrease in net patient revenue as shown in Figures 4 and 5. From FY2010 to 2011, management reduced salaried expenses by 16% and supplemented with contract services. Use of contracted services as a variable cost was appropriate for the swings in referrals and revenue. In FY2013, benefits were reduced to FY2009 levels to assist in lowering operating deficits to $27,426. In FY2014, there was a slight increase in salaried labor and benefits, but as patient admissions decreased, the use of contracted services decreased resulting in an overall decrease in total labor costs and benefits.

Figure 5:



Source: HealthWyse AR Reports 2009 – 2013; Healthcare First 2014; Municipal Budget Reports; Town Financials

Table 7 below shows the trend in payer mix by net revenue. From a reimbursement perspective, Medicare is the most desirable payer with potential to realize operational gain while Medicaid and Commercial payers are usually reimbursed at below cost of services provided. The data indicate that the largest payer source for ANS is Medicare with commercial insurers being the next largest payer. While the percentage of Medicare net revenue appears favorable, the overall volume of net Medicare revenue decreased in FY2014 resulting in a negative impact on operating margins. ***The rule of thumb for break-even operations is a payer mix that has approximately 80% Medicare net revenue with a minimum average daily Medicare census of 25 patients managed at US PPS metric benchmark levels***. While ANS exceeded various US PPS metrics in FY2009 – 2013, it lacked the adequate volume and percentage of Medicare payer mix by census which dropped from 59% in 2009 to 51% in 2012 and 47% in 2013. With the increase in managed care in MA (3rd in the US), all agencies saw these kinds of shifts in payer mix. Only those agencies with an aggressive sales force were able to maintain a financially successful payer mix. Concurrently, commercial referrals increased from FY2010 – 2014 with little change in rates (reimbursement rates for a commercial skilled nursing visit is approximately one-half the cost of providing that skilled nursing visit as shown in Figure 3) and also had a negative impact on ANS financial performance.

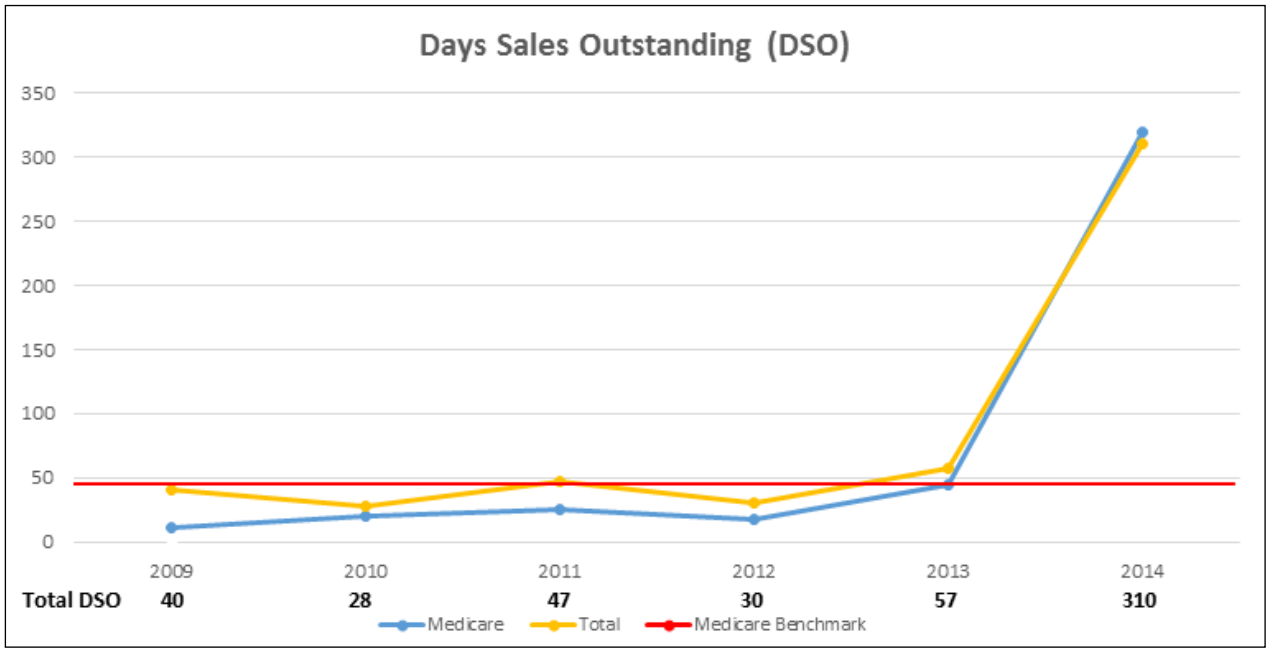
Table 7: Payer Mix as Percent of Net Revenue

	2009	2010	2011	2012	2013	2014
Medicare	78%	70%	73%	74%	63%	74%
Medicaid	0%	0%	0%	0%	1%	2%
Commercial	21%	29%	25%	24%	34%	23%
Self-Pay	0%	1%	2%	1%	2%	0%
Town				0%	1%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: HealthWyse AR Reports 2009 – 2013; Healthcare First 2014; Municipal Budget Reports

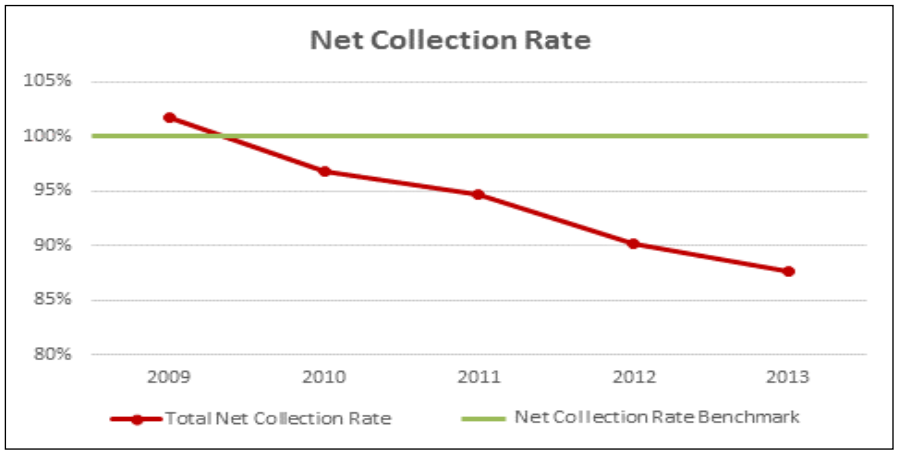
Figure 6 below reflects the accounts receivable (A/R) performance relative to the industry benchmark (red line). As evident from the chart, A/R performance performed better than national benchmarks until 2013. Software vendor error resulted in the sharp increase noted beginning in 2013. The change in Days Sales Outstanding (DSO) is likely multifactorial and may be impacted by billing vendor performance, change in payer mix (commercial claims take longer to collect) and new regulatory and insurance company requirements (Medicare Face to Face documentation). These factors are also evident in in Figure 7. Net Collection Rate (NCR) is a measure of what an entity can reasonably expect to collect. An increased percentage of commercial payers results in larger contractual adjustments. The NCR benchmark is 100% or better. Currently, ANS has a NCR of 88% across all payers.

Figure 6:



Source: HealthWyse AR Reports 2009 – 2013; Healthcare First 2014; Municipal Budget Reports

Figure 7:



Source: Agency Reports; HealthWyse AR Reports 2009 – 2013; Healthcare First 2014; Municipal Budget Reports

Table 8 below reflects bad debt write offs for the last five years. Bad debt write offs were managed well below industry benchmarks (<1%) with the exception of 2012 with a total loss of five and one-half percent (5.5%), of which the vast majority was a commercial insurance write off of $26,309 (4.7%).

Table 8: Bad Debt Write-off

Year	2010	2011	2012	2013	2014
Total Write-off	$1,882	$372	$31,030	$12,545	$2,644
Total Revenue	$675,386	$524,002	$564,117	$557,158	$273,617
% Bad Debt	0.28%	0.07%	5.50%	2.25%	0.97%

Source: Agency Reports: HealthWyse AR Reports 2009 – 2013; Healthcare First 2014; Budget Reports

Table 9 is a summary of the available data on charity care costs for Acton residents through ANS. In FY2013 and FY2014, there was a total of $20,582 and $20,817 spent on Acton residents through a funded grant from the Steinberg-Lalli Charitable Foundation. There were a total of 19 residents served in FY2014, which was an increase of 46% from the previous year. In addition, the total number of visits provided increased by 58% from the previous year. Due to the shift in personnel used (more nursing and aide with no therapy), the cost per visit per resident decreased by 36%. This report is unable to determine if the increase in residents served will be a continuing need for future years.

Table 9: Charity Care Cost

Year	2012	2013	2014
Residents Served	NA	13	19
Nursing visits	NA	90	122
Physical Therapy visits	NA	61	-
Occupational Therapy visits	NA	5	-
Aide visits	NA	41	190
Total visits	NA	197	312
Total service expenses	NA	$18,222	$16,362
Total admin expenses	NA	$2,360	$4,455
Cost per visit per resident		**$104**	**$67**

Source: Agency Reports

V. FUTURE OPTIONS

At the direction of the Board of Selectmen, in the fall of 2012 ANS leadership began a thoughtful strategic plan for the future of ANS that included the consideration of partnering with another certified agency to continue and even expand home health services for Acton residents. ANS approached Parmenter as a potential partner with HMS facilitating exploratory discussions for an agreement to provide certified skilled services in Acton. Major items discussed included mission, vision, values, public health services, customer service and quality of care, charity care, financial viability, employee relations, keeping an office open in Acton, use of the Acton name, and Board representation. After several meetings with Parmenter leadership, there was consensus to move forward with an agreement for presentation to the Board and town residents.

The Summary of Future Options is a broad description of the 2 primary programs currently provided by ANS (home health care and public health services) and the addition of a new Navigator Program. These options are not exhaustive, but are meant to provide some of the possible combinations of the decision to either surrender or keep ANS's Medicare provider number, and if surrendering the provider number, how certified skilled services could be provided to Acton residents without interruptions in accessing skilled care. Public health services could continue under the control of the Acton Health Department or be outsourced to other entities that provide public health services.

Summary of Future Options

Option 1: Keep ANS and Public Health services as is under the General Fund (keep current agency certified with public health service—no change)

Option 2: Close ANS and provide nursing and public health services by other agencies (all services for nursing and public health are outsourced to other agencies)

Option 3: Close ANS and transition to Parmenter for nursing and public health (Parmenter does both home health and public health)

Option 4: Close ANS and transition nursing services to Parmenter but keep public health in-house for Acton (Parmenter does home health and Acton keeps public health)

Option 5: Close ANS and transition nursing services to Parmenter but keep public health in-house and start a Navigator Program (same as Option 4+add Navigator Program)

Option 6: Close ANS and refer for nursing services to several agencies but keep public health and start Navigator Program (No partnership for home health and keep public health with Navigator Program)

Decision Matrix

	Keep ANS (no change)	Partner Parmenter for skilled services	Other agencies for skilled services	Public Health By Acton Town	Public Health outsourced (Parmenter or other entity)	Public Health Provided to Other Towns (Stow)	Navigator Program Under Action Town control
Option 1	**X**			**X**		**X**	
Option 2			**X**		**X**	**X**	
Option 3		**X**			**X**	**X**	
Option 4		**X**		**X**		**X**	
Option 5		**X**		**X**		**X**	**X**
Option 6			**X**	**X**		**X**	**X**

What is a Navigator Program?

Throughout this report there have been references to a Navigator Program that could assist residents in obtaining insurance, services from all types of providers, education and outreach, and other ways to integrate Town services. To better understand the role of a Navigator, the program could be designed in a number of ways to:

- Advocate for individual residents and families;
- Facilitate and coordinate community and school-based services;
- Act as a clearinghouse for information and creation of a database for contacts;
- Step in during a family crisis to arrange for mental health or health services;
- Participate in Town committees for residents at risk for health problems; and
- Provide education for all ages on management of chronic diseases and using health care wisely.

Examples of Nurse Navigator Job:

- Coordinate transportation needs for Medical Homes to ensure follow-up care;
- Set up safety net programs for vulnerable youths and seniors using a volunteer corps;
- Develop a program to encourage kids to get exercise and eat right, self-manage asthma, deal with bullying, academic stress and depression;
- Develop a community speaking program on how to navigate insurance coverage, managing out of pocket expenses, reading and understanding HIPAA privacy notices and opt outs, preparing for doctor visits with personal health records;
- Deal with a family suddenly affected by an elderly parent who needs long term care; referral to home health or private duty agency for home care;
- Research state grant opportunities for innovative community nursing services;
- Work with Acton social services to help families with MassHealth enrollment to secure insurance coverage or premium assistance;
- Develop programs for Asian and Indian population special needs spoken in native language;
- Follow up residents who have been hospitalized to be sure they have an appointment and transportation within seven days of discharge; and
- Advocate for residents to find a provider in network, or to get an appointment sooner.

VI. CONCLUSIONS

The Town of Acton had a vision for home health and public health services over 90 years ago to ensure the health of its residents in the face of the flu pandemic of 1918 followed by the Great Depression. ANS, along with many other small certified home health agencies, faces similar economic challenges compounded by the 28% decline in referrals over the last 12 months in large part due to the creation of larger networks taking patients from ANS. The Town is at a pivotal point in deciding the future of ANS and how to meet the health care needs of its residents.

While the ANS trends over the last five years show declining patient volume and reimbursement along with projected rate cuts for the next 3 years, at the same time, the Acton baby boomer demand for home care services may increase. The next two years of health care reform will shape the ability of Acton residents to have access to these home health services regardless of the Future Options plan chosen.

Increasing competition from other home care providers will continue to erode ANS market share. At the time of this report there are currently 24 certified agencies offering services in the same geographic area. Absent significant investment in marketing and other resources to support the agency, ANS will not remain viable in the current healthcare market place.

As in the past, Acton is at the forefront of towns as demonstrated by its 2020 Comprehensive Committee Plan. Consistent with the goals and objectives of the 2020 Plan, a Navigator Program could support the strategies of the 2020 Plan and help contain costs of ancillary services by acting as a safety net service to those residents most at risk. Together with the Town social services department, under Massachusetts health care reform, the Navigator could also help enroll non-US residents into MassHealth or get premium assistance and assist in securing state innovation grants. Acton could become a regional center for innovative population management services as it has for public education and transportation services.

In summary, the major goal of this study was to analyze ANS operations and financial status to guide the Board, the Finance Committee, and Acton residents on the future of ANS, including the option closing the certified home health agency. Secondly, the report summarized public health activities separately from the home health activities to determine whether these services should continue with Acton employees or under contract. (See Final Recommendations).

VII. FINAL RECOMMENDATIONS

In light of the forecasts for all home health agencies and the significant decline in patient referrals this past fiscal year along with ongoing mandated fixed costs for certified home health agencies, HMS recommends Option 5, as delineated in the summary: closing the home health **certified-only portion** of ANS and partnering with a strong agency that can survive the challenges of the next critical years and adding a Navigator Program. Despite the sense of loss of a valuable service to residents of Acton, HMS believes a *different type of home health delivery system* can be accomplished with a strong voice and presence in Acton. BUT, it must be done quickly. HMS recommends moving forward with an agreement with Parmenter that preserves

home health services similar to those provided by ANS and expands palliative and hospice services provided by Parmenter. To ensure that Acton residents receive the same level of care they have come to expect is best achieved with a Navigator Program that can, among many functions, advocate for Acton residents and coordinate care with Parmenter and other providers such as patient-centered medical homes. In short, Acton would move from a provider of home health services to a coordinator of care, maximizing resources for residents of all ages.

As for public health services, HMS recommends keeping those services under direct Acton control. Maintaining the continuity of public health services provides health maintenance and improvement for all residents that are part of population management principles. Expanding public health services under a Navigator Program oversight is also consistent with the goals of Acton's 2020 Plan.

VIII. RESPONSES TO THE QUESTIONS RAISED BY THE BOARD OF SELECTMEN/ FINANCE COMMITTEE/PUBLIC

1. How many Acton residents (unduplicated count) have used ANS services?

Over the last 5 years, ANS has provided home health care to an average of 171 unduplicated patients per year (167 in 2009 to 219 in 2013). Agency reports were not available to break down the unduplicated census by town; however, based on the total admissions for Acton residents (79%), an estimate of unduplicated patients for 2009 – 2013 was 160 – 168 per year Acton residents had services. These unduplicated counts represent all residents that received home health services, including charity care billed to a grant in 2013 and 2014. Prior to this charity care fund, a small number of uninsured Acton residents also received home health services from 2009 - 2012.

2. What is the demographic breakdown for those residents who have received services?

Unfortunately, ANS software did not capture demographics (age, race, gender, marital status). From Medicare claims submitted, 89% of patients served were 65 years of age or older.

3. What percentage of services provided to those residents could be performed by another certified home health agency?

Any of the 24 certified home health agencies certified by Medicare and listed as servicing Acton can provide the Medicare services that ANS provided. This does not suggest that all agencies have availability of in-demand caregivers such as rehabilitation therapists that could result in a waiting list for those services; nor does the certification status guarantee the same quality of care outcomes and patient satisfaction or the same level of Medicare services as provided by ANS staff since that is controlled by the specific agency. The visit utilization for ANS under Medicare is consistent with national statistics with the exception of nursing and home health aide services that were provided at a higher level. Also, ANS provided services to 2 Medicare patients requiring extensive care that were outliers (PPS revenue was less than the cost of care). It is not known if other agencies would accept these kinds of outliers given the losses generated. Lastly, the charity care provided to Acton residents would not likely be provided by the other certified agencies unless a funding source was made available to the agency.

As for non-Medicare services, it is not know at this time if all 24 agencies contract with the same commercial carriers as ANS to provide services that were paid by those health plans.

All of these issues have been discussed with Parmenter as terms for an agreement to ensure an orderly transfer of care for active patients.

4. Is there a business model with a business plan that could sustain ANS without Town subsidization (break even budget)?

ANS shares the same business challenges as all home health agencies—growing costs from mandated regulations yet shrinking reimbursement. These factors coupled with the downward trend in referrals causing loss of volume make it highly unlikely that any agency without a significant growth plan and contracts with larger networks will be able to survive without other funding.

5. How can services be provided through a local number to call?

Discussions with Parmenter have included maintaining a local presence in Acton so residents can access care as they have in the past. Specific telecommunications options include local telephone numbers that may point to a centralized intake still giving residents a local number to call.

6. Is it possible to keep a local presence if ANS is closed?

Again, discussions have included this desire to keep an office in Acton.

7. What is a Medical Home and how will that change providing home health services?

A Patient-Centered Medical Home is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. This includes the provision of preventive services; treatment of acute and chronic illness; and assistance with end-of-life issues. This care model promotes improved access and communication; care coordination and integration; and care quality and safety. In a patient-centered medical home, a primary care provider and members of his or her team coordinate all of a patient's health needs, including management of chronic conditions, visits to specialists, hospital admissions, and reminding patients when they need check-ups and tests. The medical home model supports fundamental changes in primary care service delivery and payment reforms, with the goal of improving health care quality. It is not possible to predict how a medical home model will affect the provision of home health care services, but with the Commonwealth's push for all medical practices to become medical "homes" in 2015, it is advisable to educate the residents and offer assistance with these changes.

8. What is the defined problem to be solved?

Over the last three years, the Board has recognized the value of ANS to Acton residents with a growing concern about the ability of the agency to stand on its own financially. The problem to be solved is how to continue providing the local based home health care in the face of greater financial dependence on the enterprise funds to remain a certified home health agency with the inherent costs of certification. The solution being explored is a partnership with an agency with a similar mission and community focus while maintaining a presence in the town. In addition to the certified home health services, ANS has provided mandatory public health services and voluntary community services under a separate budget. Those services have a fixed cost without the associated overhead costs of a certified home health agency. A contract with the

Town of Stow to provide its public health services has also been budget neutral and self-sustaining.

9. What separate nursing and public health services have been provided?

Home Health and Public Health visits and time were collected for analysis. See Table 2 for the breakdown of visits and hours for both programs. It should be noted that beginning in 2012, a discreet public health budget was used with allocation of shared employees (doing both home health and public health services). At the close of FY12, the allocations were reviewed to actual and increased approximately 3% for FY13. All public health activities were tracked in the agency software program in 2012 and 2013; however, with the conversion to a new, lower cost software vendor in 2014, the software could not track these activities and a manual tracking was used.

10. How can the Town provide service for the elderly (20%) and non-elderly?

Home health services are covered under the Medicare program and 100% billable to Medicare when an agency is Medicare certified. Regardless of what future option is recommended for Town approval, elderly residents may continue to receive home health services from one of 24 certified home health agencies. In the last several months, the ANS leadership has been exploring models of care to serve residents of all ages using a nurse navigator. See discussion of a nurse navigator role. The leadership of ANS believes that the navigator concept is consistent with the Acton 2020 Plan to support citizens with disabilities in participating fully in the life of the community (Objective 5.4); to provide high quality services that are responsive to community needs (Objective 6.4); and to provide excellent public health and safety services (Objective 6.5).

11. What are the projections for government payments in the short and long term?

The 2015 proposed Medicare payment rates were recently released with an estimated 1.45% reduction. With an additional sequestration (2% each year) through 2020, the 5-year reduction is projected to be 3.5 - 9% depending on the specific recalibrated Home Health Resource Group (HHRG) ANS will use. The Medicare Payment Advisory Committee (MedPAC) is recommending similar cuts for the next 3 years.

12. How can the Town provide assistance to help with managed care barriers?

Navigators are best suited to overcome barriers such as finding providers in a network and obtaining care timely that is coordinated with primary care and specialty providers. Research shows that when care is coordinated and timely, outcomes improve and costs are reduced. As health plan benefits under managed care change with potentially higher deductibles and copays, residents may be at risk of obtaining timely care to avoid out of pocket expense with the potential of negative health outcomes. This is where the Town of Acton can provide advocacy and education for its residents on how to use insurance coverage appropriately.

13. What is the cost of services and clearly articulated value to residents that makes common sense to residents?

The cost to operate a certified home health agency would be at a minimum of $250,000 per year. Public health services would cost approximately another $130,000 per year. Placing a value on these services is both a financial calculation and a philosophical determination. Elderly residents may see direct care in their home as the most valuable service, where non-elderly

residents may value a healthy community for families. The common sense test is how to put a dollar value on these services that are immediate and some that are long term.

14. How is ANS different from other agencies that service Acton?
CMS publicly reports each certified agency's performance on 22 outcomes and 5 patient satisfaction scores with the ability to compare an agency to any other agency. Over the last 5 years, ANS has outperformed local competitors, all Massachusetts agencies, and all US agencies on 7 of 22 outcomes and all 5 patient satisfaction scores putting them in the OCS Elite category of **top 500 agencies in the country** for the last 2 years (note: there are over 10,000 certified agencies nationwide). With CMS focus on avoidable hospitalizations and penalties for readmission within 30 days, ANS has scored far above all agencies with an extremely low readmission rate (11%) compared to all other US agencies (16%). Patient satisfaction scores are even more favorable on all 5 reported by CMS. It is these kinds of quality outcomes that health care reform will demand.

15. Are there other high quality agencies that could provide the same services as ANS?
While there are 24 other Medicare certified home health agencies that could provide care to Acton residents, the leadership of ANS vetted out several partners for home health services and felt that Parmenter is the best choice based on its commitment to community services and the availability of additional services for Acton resident such as hospice and palliative care. Acton currently contracts with Parmenter for rehabilitative services and has had a positive experience dealing with the agency.

16. What will be the impact to residents if ANS closes?
Negotiations with Parmenter have focused on maintaining as close to ANS services and direct care providers as Acton residents have had in the past without violating local regulations. One of the criteria for the Future Options was control over services provided with each of the options considered. Partnering with a single certified agency, as opposed to referring to multiple agencies, gives Acton the potential to voice needs and concerns more directly including at an advisory board level.

17. Are there other municipalities with successful models and examples of success?
Of the 351 towns and cities in Massachusetts, there are two certified local government controlled agencies. Several municipalities have public health nurses on staff for mandated public health activities. Meriden, CT is one example of a public health program with 10 essential services that is a model for municipalities under health care reform. These services include:

1. Monitoring health status to identify and solve community health problems.
2. Diagnosing and investigating health problems and health hazards in the community.
3. Informing, educating, and empowering people about health issues.
4. Mobilizing community partnerships and action to identify and solve health problems.
5. Developing policies and plans that support individual and community health efforts.
6. Enforcing laws and regulations that protect health and ensure safety.
7. Linking people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assuring competent public and personal health care workforce.
9. Evaluating effectiveness, accessibility, and quality of personal and population- based health services.

10. Researching new insights and innovative solutions to health problems.

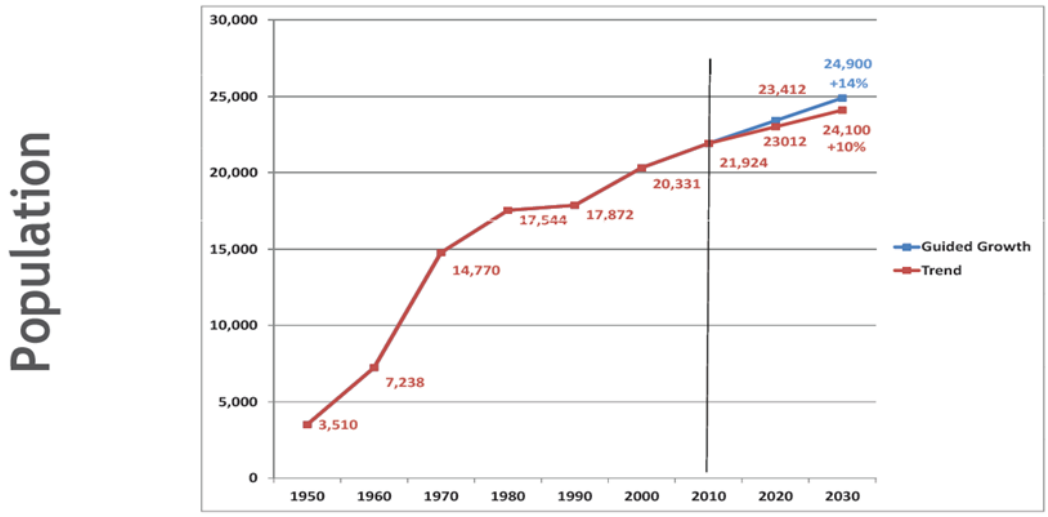
(See Meriden CT Annual Report 2012 – 2013 in Appendix I)

As the Massachusetts health care reform moves toward community-based prevention, public health, and wellness efforts to reduce the cost of preventable chronic diseases (obesity, diabetes, asthma), Acton public health services could be expanded to all age groups with an innovative Navigator Program with potential funding from competitive grants to municipalities

18. Are there enough certified home health agencies to serve 21,000 residents? Will the Town need to provide public support for Acton residents if ANS closes?

US demographic projections for 2020 show 1000 new Medicare beneficiaries per day.

The 2020 Plan for Acton projects 20% of residents 65 or older by 2020 with a total population of 23,412 (see graph below). This demographic change is going on across the US, and the demand for home health services will rise. It is not clear if the projected closures of agencies will impact accessing home health services.



In 2000 roughly 7.2 million individuals received home care services or approximately 2.5% of the US population (see NAHC Basic Statistics Report in Appendix G). This report goes on to say that a 2009 Caregiving in the US Survey, sponsored by AARP found that more than one in three US households are informal caregivers for a person over 18. The same survey showed that formal professional caregivers in Medicare certified home health agencies such as ANS included nearly 1 million caregivers with predominantly RNs and home care aides representing half of all caregivers.

With the short and long term cuts in Medicare home health reimbursement, it is not clear how many of the 24 certified agencies servicing Acton will close. This could increase the demand for services beyond the supply of available certified agencies. Again, this is where a Nurse Navigator could facilitate obtaining these services as health care reform unfolds.

19. Three years ago recommendations were made to decrease costs and increase marketing efforts. Has that occurred?

Due to limited funds, a formal marketing plan could not be developed. The marketing budget did provide for a complete revision of agency collaterals in 2012 and sales efforts continued with existing staffing and advertising and promotion through Minute Man Senior Services (March for Meals, Holiday Auction, and Volunteer Appreciation Luncheon) and professional services

through Quality Graphics, Patch Media, Positive Promotions, and Naylor Marketing). Total expenditures for marketing have been less than 3% of the total budget. Given the limitations of a dedicated sales force to secure more Medicare referrals in a highly competitive market, patient referrals have dropped 28% from 2013 to 2014.

20. Is ANS a business with expectations of financial independence or a service that needs Town funding?

All health care providers must adhere to sound business practices in the provision of health care services to remain viable. Those home health agencies that provide services with outstanding clinical outcomes and patient satisfaction may not be financially viable putting them in jeopardy. The leadership of Acton must decide if the value of ANS service warrants the level of Town funding or subsidization.

21. How can the Town create a sense of community welcoming and caring for its own residents to attract and encourage residents to remain in Acton?

Acton is a diverse cultural and ethnic diversity and a range of other demographic factors (age, income, single family homes). Creating a caring community takes commitment to break down social and economic barriers with determination to welcome all its citizens. The Acton 2020 Plan proposed over 200 action steps one of which was "the creation of a new committee composed of liaisons from various ethnic and language groups in Town to provide information to newcomers and assist with organizing multi-cultural activities. This will help build bridges, knitting the community closer together, and it will provide guidance to those unfamiliar with the Town and its resources." (Page 9 Acton 2020 Comprehensive Community Plan).

22. How much and what type of charity care has been provided (number of uninsured and underinsured Acton residents served)?

The Steinberg-Lalli Charitable Foundation pledged $120,000 over three years from 20013 – 2015 to provide care to uninsured and under-insured Acton residents. The chart below quantifies residents and services provided each of the 2 years and administrative costs associated with this care:

Grant Year	**2013**	**2014**
Residents served	13	19
Nursing visits provided	90	122
Physical Therapy visits provided	61	0
Occupational Therapy visits provided	5	0
Aide visits provided	41	190
Total visits provided	197	312
Total service expenses	$18,222	$16,362
Total admin expenses	$2,360	$4,455

23. Will a Town-funded program for uninsured attract more uninsured resident increasing demand for services in excess of funds?

Allocating limited funding for charitable care will continue. The demand for care will continue to stretch Town resources in all departments with the need to plan and prevent as much strain on the Town's existing services, particularly if ANS is closed and home health services are provided by Parmenter or other certified agencies. Tapping funding through competitive state grants can also help reduce dependence on town enterprise funds. Eligibility criteria for these funds can help curb demands exceeding the funding.

24. How can Acton continue to support efforts of the Safety Net Program?
Having a Navigator Program advocate/coordinator is the most direct and efficient way to support the Town's Safety Net Program. Ongoing representation of a nurse navigator brings the experience of providers who understand care delivery and how to access services.

25. How can Acton support resident privacy in integrated health networks?
Privacy regulations are clearly spelled out in HIPAA rules. Educating the residents on HIPAA privacy rules including the right to health records and how to opt out can help alleviate concerns about privacy breaches.

26. Can the public health services remain in-house and home health services outsourced?
This option is listed in Option 1, 2, 4, 5, 6 described above.

27. If ANS closes, what will happen to active patients? How will the transition to another agency occur without interruption of services?
Home Health regulations require an orderly transfer of patients at any point in a patient's care. In the dissolution of a certified agency, all patients' care must be transferred without interruption of services. This is best done with an acquisition partnership arrangement where patients' care can be transitioned over a short period with optimal continuity of care with prior caregivers wherever possible. Negotiations with Parmenter have included a transition plan that would be detailed out at the patient level to avoid interruption of services.

28. In light of Massachusetts' push toward ACOs, how will the ACA change how residents get services and how will those services be paid?
The Massachusetts Executive Office of Health and Human Services (EOHHS) and the Department of Public Health have received $950,000 in 2013 and $2.23M in 2014 for health care reform. Prevention and Wellness Trust will invest $57M over 4 years in community prevention activities funded through industry assessments with a model wellness guide that also includes a wellness tax credit for small businesses. All these new funds are opportunities for Acton to develop and finance a Navigator Program to help residents get services.

29. What is the direct care employee turnover rate for ANS, Parmenter, and other Massachusetts agencies?
ANS employee turnover rate from 2009 – 2014 has remained low compared to Massachusetts home health agencies (data from Home Care Alliance of Mass indicated a rate twice that of ANS). Three full-time and 1 part-time employees resigned for personal reasons. All positions were filled without interruption of services. The average current employee tenure with ANS is 7 years. The recent resignation of the Administrator will require strategic decision making for the Future Options.

30. How can the Town provide a more holistic program that supports the Safety Net Program and encourages the residents to look out for each other?
The vision for a Navigator Program includes incorporating all resident participation in the health and well-being of Acton residents with a heavy emphasis on a volunteer corps for all ages.

Securing new sources of funds and building on the existing interdepartmental approach to a holistic plan would support the Safety Net Program concept.

31. With the ACA changing rapidly, what will be the transition plan if ANS closes?
A transition plan has already been discussed for active patients and existing employees. With the challenges facing ANS in 2015, all contingencies for closure should be explored in 2014.

32. What is the actual taxpayer burden for ANS?
Much like a per pupil cost per resident is calculated, a per patient cost per resident could be calculated.

33. What data will give the residents a clear understanding of what services and spending has occurred?
As Board and Finance Committee members have stated previously, once the Town reaches consensus on the value of funding the agency's deficit versus closing the agency and partnering with Parmenter, then a clear vision and direction can be presented to the residents. It may take taking points and town hall meetings to clearly understand the residents' wishes (and fears) in a rationale manner providing financial data to move toward acceptance of the future option.

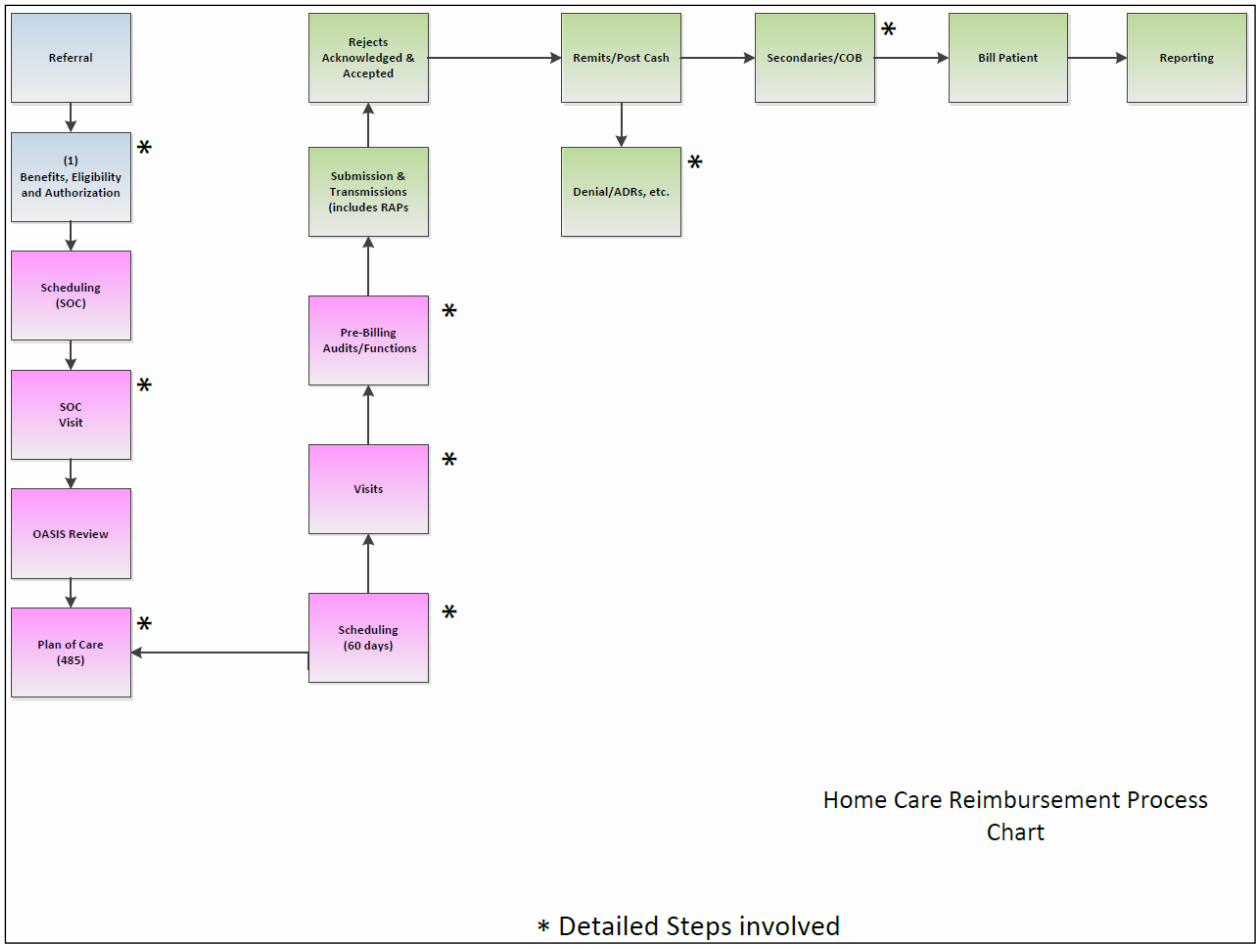
IX. APPENDICES

A. Town of Acton Demographics

B. Home Health Compare scores

Outcome (Improvement)	ANS	Emerson Hospital	Nashoba	MA	US
Ambulation	79%	62%	62%	64%	62%
Transfers	71%	63%	65%	61%	57%
Bathing	65%	68%	69%	68%	68%
Pain assess	100%	100%	100%	98%	99%
Pain treatment	100%	100%	99%	99%	98%
Pain with movement	85%	67%	79%	71%	68%
CHF treatment	NA	98%	98%	99%	98%
SOB improvement	94%	70%	58%	68%	65%
Surgical wound imp	NA	95%	86%	92%	89%
Pressure ulcer risk assess	97%	99%	100%	99%	99%
Pressure ulcer prevent	NA	98%	100%	97%	97%
Pressure ulcer treatment	NA	98%	99%	97%	97%
Start care in 48 hours	95%	98%	92%	94%	92%
Drug education	100%	99%	98%	95%	93%
Oral drug mgt improve	55%	57%	57%	55%	51%
Fall risk assessment	100%	100%	100%	97%	98%
Depression assess	100%	99%	98%	98%	98%
Flu vaccination	NA	86%	87%	75%	72%
Pneumococcal vacc	86%	93%	90%	70%	72%
DM foot care orders	NA	98%	98%	95%	94%
Utilization (lower better)					
ED use (Medicare only)	16%	12%	12%	12%	12%
Hospital use (Medicare only)	11%	16%	19%	16%	16%
NA	Insufficient # patients				
Patient Satisfaction					
Professional care	96%	92%	88%	88%	88%
Communication	94%	89%	85%	86%	85%
Med, pain, safety teaching	92%	87%	85%	86%	85%
Overall rating	97%	91%	83%	85%	84%
Recommend agency	96%	89%	85%	81%	79%
Source: CMS Home Health Compare website, 2014					
	Exceeds competition, MA, and US				

C. Standard Revenue Cycle Management chart



D. CMS Health Care Innovation Awards: Massachusetts

BETH ISRAEL DEACONESS

Project Title: "Preventing avoidable re-hospitalizations: Post-Acute Care Transition Program (PACT)"

Geographic Reach: Massachusetts

Funding Amount: $4,937,191

Estimated 3-Year Savings: $12,900,000

Summary: Beth Israel Deaconess Medical Center of Boston, Massachusetts, is receiving an award to improve care and reduce hospital readmissions for over Medicare and beneficiaries dually eligible for Medicare and Medicaid who represent over 8000 discharges for conditions such as congestive heart failure, acute myocardial infarctions, and pneumonia. By integrating care, improving patients' transitions between locations of care, and focusing on a battery of

evidence-based best practices, this model is expected to prevent complications and reduce preventable readmissions, resulting in better quality health care at lower cost in the urban Boston area with estimated savings of almost $13 million over 3 years. Over the three-year period, Beth Israel's program will train an estimated 11 health care workers, while creating an estimated 11 new jobs. These workers will include care transition specialists who will help integrate care between hospital and primary care practices.

HEALTH RESOURCES IN ACTION

Project Title: "New England asthma innovations collaborative"

Geographic Reach: Connecticut, Massachusetts, Rhode Island, Vermont

Funding Amount: $4,040,657

Estimated 3-Year Savings: $4,100,000

Summary: Health Resources in Action is receiving an award for a program of its New England Asthma Regional Council, titled the New England Asthma Innovations Collaborative (NEAIC). NEIAC is a multi-state, multi-sector partnership that includes health care providers, payers, and policy makers aimed at creating an innovative Asthma Marketplace in New England that will increase the supply and demand for high-quality, cost-effective health care services. Over the three year funding period, services will be delivered to over 1400 children ages 2-17 with persistent asthma who have had at least one related emergency department visit, observation stay, hospitalization or received a prescription in the 12 months prior to enrollment. The intervention will lower costs of asthma care by delivering cost-effective prevention oriented care in clinics and at home to reduce preventable pediatric-related emergency department visits and hospital admissions with estimated savings of over $4 million. NEAIC will also train an estimated 64 health care workers, while creating an estimated 17 new jobs. These workers will include well-trained community health workers and asthma educators. Finally, NEAIC will work to sustain these cost-effective services by piloting reimbursement methodologies with payers. In sum, NEAIC will create a new type of workforce and service delivery model that targets cost-effective and culturally competent care, which features patient self-management education, environmental interventions and long-term sustainability payment mechanisms of these services.

INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT

Project Title: "Care management of mental and physical co-morbidities: a TripleAim bulls-eye"

Geographic Reach: California, Colorado, Iowa, Massachusetts, Michigan, Minnesota,

Pennsylvania, Washington, Wisconsin

Funding Amount: $17,999,635

Estimated 3-Year Savings: $27,693,046

Summary: The Institute for Clinical Systems Improvement (ICSI) of Bloomington, Minnesota is receiving an award to improve care delivery and outcomes for high-risk adult patients with Medicare or Medicaid coverage who have depression plus diabetes or cardiovascular disease.

The program will use care managers and health care teams to assess condition severity, monitor care through a computerized registry, provide relapse and exacerbation prevention, intensify or change treatment as warranted, and transition beneficiaries to self-management. The partnering care systems include clinics in ICSI, Mayo Clinic Health System, Kaiser Permanente in Colorado and Southern California, Community Health Plan of Washington, Pittsburgh Regional Health Initiative, Michigan Center for Clinical Systems Improvement, and Mount Auburn Cambridge Independent Practice Association with support from HealthPartners Research Foundation and AIMS (Advancing Integrated Mental Health Solutions).

Over a three-year period, ICSI and its partners will train the approximately 80+ care managers needed for this new model.

MAYO CLINIC

Project Title: "Patient-centric electronic environment for improving acute care performance"

Geographic Reach: Massachusetts, Minnesota, New York, Oklahoma

Funding Amount: $16,035,264

Estimated 3-Year Savings: $81,345,987

Summary: The Mayo Clinic, in collaboration with US Critical Illness and Injury Trials Group and Philips Research North America, is receiving an award to improve critical care performance for Medicare/Medicaid beneficiaries in intensive care units (ICUs). Data shows that 27% of such Medicare beneficiaries face preventable treatment errors due to information overload among ICU providers. The Mayo Clinic model will enhance effective use of data using a Cloud-based system that combines a centralized data repository with electronic surveillance and quality measurement of care responses. As a result, Mayo expects to reduce ICU complications and costs.

Over a three-year period, the Mayo Clinic will train 1440 existing ICU caregivers in four diverse hospital systems to use new health information technologies effectively in managing ICU patient care.

NORTHEASTERN UNIVERSITY

Project Title: "Integrating industrial and system engineering (ISE) methods into healthcare improvement"

Geographic Reach: Massachusetts, North Carolina, Washington

Funding Amount: $8,000,002

Estimated 3-Year Savings: $60,780,907

Summary: The Healthcare Systems Engineering Institute at Northeastern University is receiving an award to establish a regional system engineering extension center that will embed proven evidence-based industrial and system engineering (ISE) improvement methods into local healthcare organizations, similar to as used in other complex industries. This demonstration project will launch a network of similar centers across the U.S. to significantly improve care, cost,

safety, and quality starting first in Massachusetts, expanding to Washington and North Carolina states during the grant period, and continuing thereafter. Engineers and healthcare professionals will be cross trained in applying these methods to important healthcare problems and work together in engineer-clinician project teams, integrating industrial engineers directly into health systems, establishing internship and summer residency programs, and creating trans-disciplinary curricula for engineers, clinicians, and healthcare managers. The overall goal is to measurably demonstrate the clear value of ISE methods and such a regional extension program, expanded nationally, to significantly lower costs, improve access, and achieve better outcomes, leading to better care and higher patient safety.

Over a three-year period, Northeastern University's program will train an estimated 81 workers in healthcare systems engineering methods and create an estimated 10 new jobs to educate students, oversee applied projects, and manage experiential education.

THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

Project Title: "Community health workers and HCH: a partnership to promote primary care"

Geographic Reach: California, Florida, Illinois, Massachusetts, Nebraska, New Hampshire, North Carolina, Texas

Funding Amount: $2,681,877

Estimated 3-Year Savings: $1,500,000

Summary: The National Health Care for the Homeless Council is joining into a cooperative agreement to serve ten communities across various regions in the U.S. to reduce the number of emergency department visits and lack of primacy care services for over 1700 homeless individuals. The intervention will integrate community health workers into Federally Qualified Health Centers to conduct outreach and case coordination for transitioning this population from the emergency department to a health center, thus reducing unnecessary emergency department visits and improving quality of care for this population with estimated savings of approximately $1.4million. Over the three-year period, National Health Care for the Homeless Council's program will train an estimated 101 health care workers, while creating an estimated 17 new jobs. The workers will include community health workers who will conduct outreach and care coordination.

SAN FRANCISCO COMMUNITY COLLEGE

Project Title: "Transitions clinic network: linking high-risk Medicaid patients from prison to community primary care"

Geographic Reach: Alabama, California, Connecticut, District of Columbia, Maryland, Massachusetts, New York, Puerto Rico

Funding Amount: $6,852,153

Estimated 3-Year Savings: $8,115,855

Summary: The San Francisco Community College District (City College of San Francisco), in partnership with the University of California San Francisco and Yale University, is receiving an award to address the health care needs of high-risk/high-cost Medicaid and Medicaid-eligible patients released from prison, targeting eleven community health centers in six states, The District of Columbia, and Puerto Rico. The program will work with the Department of Corrections to identify patients with chronic medical conditions prior to release and will use community health workers trained by City College of San Francisco to help these individuals navigate the care system, find primary care and other medical and social services, and coach them in chronic disease management. The outcomes will include reduced reliance on emergency room care, fewer hospital admissions, and lower cost, with improved patient health and better access to appropriate care.

Over a three-year period, the San Francisco Community College District's program will create an estimated 12.3 jobs and train an estimated 53.7 workers. The new workforce will include 7 community health workers, 11 part-time panel managers, 2 part-time project coordinators, one research analyst and two part-time project staff.

TransforMED

Project Title: "Multi-community partnership between TransforMED, hospitals in the VHA system and a technology/data analytics company to support transformation to PCMH of practices connected with the hospitals and development of "Medical Neighborhood"

Geographic Reach: Alabama, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Michigan, Mississippi, Nebraska, Oklahoma, West Virginia, Wisconsin

Funding Amount: $20,750,000

Estimated 3-Year Savings: $52,824,000

Summary: TransforMED, in partnership with 12 VHA-affiliated hospitals throughout the county, is receiving an award for a primary care redesign project to support care coordination among Patient-Centered Medical Homes (PCMH), specialty practices, and hospitals, creating "medical neighborhoods." The project will use a sophisticated analytics engine to identify high risk patients and coordinate care across the medical neighborhood while driving PCMH transformation in a number of primary care practices in each community. Truly comprehensive care will improve care transitions and reduce unnecessary testing, leading to lower costs with better outcomes.

Over a three-year period, TransforMED's program will train an estimated 3,024 workers and create an estimated 22 jobs. The new workers will include an innovation project manager, project control specialists, project managers, an implementation team, a project team, an integration architect, an application trainer, and a population health management advisor.

TRUSTEES OF DARTMOUTH COLLEGE

Project Title: "Engaging patients through shared decision making: using patient and family activators to meet the triple aim"

Geographic Reach: California, Colorado, Idaho, Iowa, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Oregon, Texas, Utah, Vermont, Washington

Funding Amount: $26,172,439

Estimated 3-Year Savings: $63,798,577

Summary: The Trustees of Dartmouth College is receiving an award to collaborate with 15 large health care systems around the country to hire Patient and Family Activators (PFAs). The PFAs will be trained to engage in shared decision making with patients and their families, focusing on preferences and supplying sensitive care choices. PFAs may work with patients at a single decision point or over multiple visits for those with chronic conditions. It is anticipated that this intervention will lead to a reduction in utilization and costs and provide invaluable data on patient engagement processes and effective decision making—leading to new outcomes measures for patient and family engagement in shared decision making.

Over a three-year period, the Trustees of Dartmouth College-sponsored program will train 5,775 health care workers and create 48 positions for patient and family activators.

UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER

Project Title: "Brookdale Senior Living (BSL) Transitions of Care Program"

Geographic Reach: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin

Funding Amount: $7,329,714

Estimated 3-Year Savings: $9,729,702

Summary: The University of North Texas Health Science Center (UNTHSC), in partnership with Brookdale Senior Living (BSL), is receiving an award to expand and test the BSL Transitions of Care Program which is based on an evidenced-based assessment tool called Interventions to Reduce Acute Care Transfers (INTERACT) for residents living in independent living, assisted living and dementia specific facilities in Texas and Florida. In addition, community dwelling older adults who receive BSL home health services will be included in the Transitions of Care Program. Over the course of the award the program will expand to other states where BSL communities are located. The program will employ clinical nurse leaders (CNLs) to act as program managers. CNLs will train care transition nurses and other staff on the use of INTERACT and health

information technology resources to help them identify, assess, and manage residents' clinical conditions to reduce preventable hospital admissions and readmissions. The goal of the program is to prevent the progress of disease, thereby reducing complications, improving care, and reducing the rate of avoidable hospital admissions for older adults.

Over a three-year period, the University of North Texas Health Science Center's program will train an estimated 10,926 workers and create an estimated 97 jobs for clinical nurse leaders and other health care team members.

VALUEOPTIONS, INC.

Project Title: "Using recovery peer navigators and incentives to improve substance abuse

Medicaid client outcomes and costs"

Geographic Reach: Massachusetts

Funding Amount: $2,760,737

Estimated 3-Year Savings: $7,841,498

Summary: ValueOptions, Inc., and its subsidiary, Massachusetts Behavioral Health Partnership, is receiving an award to test care coordination to reduce repeated utilization of detox services among beneficiaries who have 2 or more detox admissions. The project uses patient navigators, recovery planning, and other support services. Four providers will implement the intervention, serving northeastern Massachusetts, southeastern Massachusetts, greater Boston, and the central portion of the state. By linking beneficiaries with appropriate treatment and recovery services, the model will improve their health outcomes, reducing costs by avoiding preventable emergency room visits and hospitalizations.

Over a three-year period, ValueOptions, Inc.'s program will train an estimated 75 workers and will create an estimated 75 jobs. The new workers will include patient navigators and trainers and support staff.

VINFEN CORPORATION

Project Title: "Community-based health homes for individuals with serious mental illness"

Geographic Reach: Massachusetts

Funding Amount: $2,942,962

Estimated 3-Year Savings: $3,792,020

Summary: The Vinfen Corporation, in partnership with Bay Cove Human Services, North Suffolk Mental Health, Brookline Mental Health, and Commonwealth Care Alliance (a non-profit managed care organization), is receiving an award to integrate health care and behavioral health care for individuals with serious mental illness in metropolitan Boston. The program will embed nurse practitioners backed by primary care doctors in existing psychiatric rehabilitation teams, creating community-based health homes that will provide better care at lower cost for a population at risk for severe chronic disease and often in need of critical care. Care management counselors and peer counselors will help people self-manage their medical and behavioral

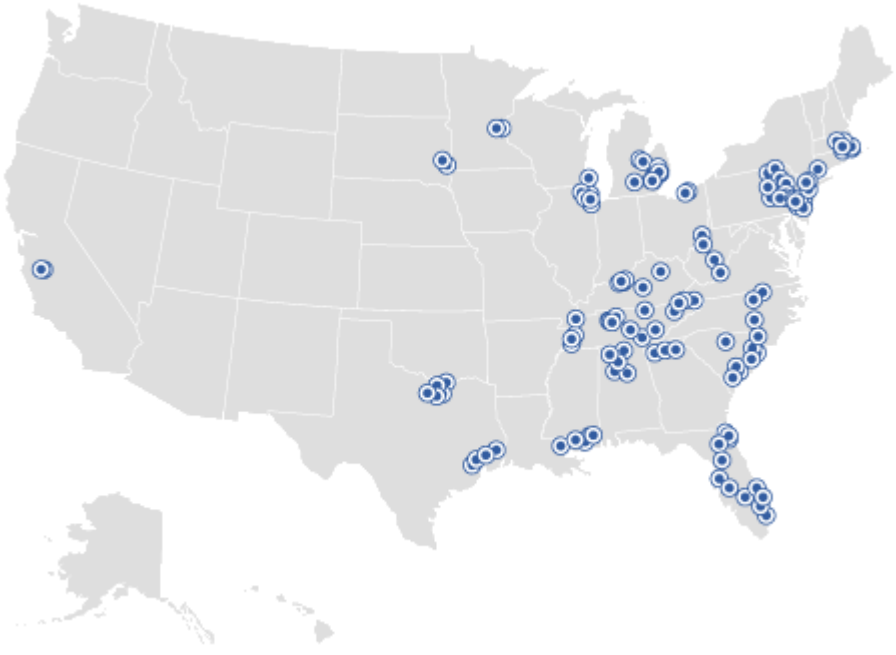
health issues. Telehealth technology will enable health care teams to monitor patients, prioritize care, and intervene as necessary. As a result, the program will improve the health of individuals with serious mental illness, increase their access to health services, reduce the impact of their disorders, and reduce avoidable use of acute services.

Over a three-year period, Vinfen Corporation's program will train an estimated 57 workers. It will create an estimated 11 jobs for health outreach workers, nurse practitioners, a primary care physician, and a project manager.

E. BUNDLED PAYMENTS FOR CARE IMPROVEMENT

BPCI Model 3: Retrospective Post Acute Care Only

Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.
For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or **home health agency**. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes.



Source: Centers for Medicare & Medicaid Services

There are 17 participating sites involved in the BPCI Model 3: Retrospective Post Acute Care Only.

Background

In both Models 2 and 3, the bundle will include physicians' services, care by post-acute providers, related readmissions, and other related Medicare Part B services included in the episode definition such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies; and Part B drugs. A target price will be set that will be based on historical fee-for-service payments for the participant's Medicare beneficiaries in the episode and will include a discount. Payments will be made at the usual fee-for-service payment rates, after which the aggregate Medicare payment for the episode will be reconciled against the target price. Any reduction in expenditures beyond the discount reflected in the target price will be paid to the participant and may be shared among their provider partners. Any expenditures that are above the target price will be repaid to Medicare by the participant.

Medicare currently makes separate payments to providers for the services they furnish to beneficiaries for a single illness or course of treatment, leading to fragmented care with minimal coordination across providers and health care settings. Payment is based on how much a provider does, not how well the provider does in treating the patient.

Research has shown that bundled payments can align incentives for providers – hospitals, post acute care providers, doctors, and other practitioners – to partner closely across all specialties and settings that a patient may encounter to improve the patient's experience of care during a hospital stay in an acute care hospital, and during post-discharge recovery.

The Bundled Payments for Care Improvement initiative includes two phases for Models 2, 3, and 4. Phase 1, also referred to as the "preparation" period, is the initial period of the initiative during which CMS and participants prepare for implementation and assumption of financial risk. Those participants in Phase 1 of Models 2, 3, and 4 that are approved by CMS and intend to assume financial risk for episodes may enter into a Bundled Payments for Care Improvement Model agreement with CMS as Awardees and begin Phase 2, also referred to as the "risk-bearing" period.

On January 31, 2013, the first set of Bundled Payments for Care Improvement Phase 1 participants were announced. Phase 2 will begin either on October 1, 2013 or January 1, 2014 for Awardees that have entered into Model agreements with CMS, at which point Awardees will begin the risk-bearing phase for some or all of their episodes. The complete transition of all episodes for all episode initiators to Phase 2 will be completed by October 2014. During the transition period, Phase 2 Awardees may transition episodes and/or episode initiators that have remained in Phase 1 to Phase 2 on a quarterly basis. By November 2013, current Awardees and Phase 1 participants may also identify additional episodes and/or episode initiators to join Phase 1.

Phase 1 will end in Fall 2014 for all participants, and all episodes that Awardees have not transitioned to Phase 2 will be withdrawn from the Bundled Payments for Care Improvement initiative.

Models run at the State level

Model Name	Organization Name	State	Notes
Health Care Innovation Awards	ValueOptions, Inc.	MA	Participant operating in **Massachusetts**
Health Care Innovation Awards	Trustees Of Dartmouth College	MA	Participant operating in California, Colorado, Idaho, Iowa, Maine, **Massachusetts**, Michigan, Minnesota, New Hampshire, New Jersey, New York, Oregon, Texas, Utah, Vermont, and Washington
Health Care Innovation Awards	Northeastern University	MA	Participant operating in **Massachusetts**, North Carolina, and Washington
Health Care Innovation Awards	The National Health Care for the Homeless Council	MA	Participant operating in California, Florida, Illinois, **Massachusetts**, Nebraska, New Hampshire, North Carolina, Texas
Health Care Innovation Awards	Beth Israel Deaconess Medical Center	MA	Participant operating in **Massachusetts**
Health Care Innovation Awards	TransforMED	MA	Participant operating in Alabama, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, **Massachusetts**, Michigan, Mississippi, Nebraska, Oklahoma, West Virginia, and Wisconsin
Health Care Innovation Awards	Vinfen Corporation	MA	Participant operating in **Massachusetts**
Health Care Innovation Awards	Health Resources In Action	MA	Participant operating in Connecticut, **Massachusetts**, Rhode Island, Vermont

Health Care Innovation Awards	University Of North Texas Health Science Center	MA	Participant operating in Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, **Massachusetts**, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, and Wisconsin
Health Care Innovation Awards	Institute For Clinical Systems Improvement	MA	Participant operating in California, Colorado, **Massachusetts**, Michigan, Minnesota, Pennsylvania, Washington, and Wisconsin
Health Care Innovation Awards	San Francisco Community College	MA	Participant operating in Alabama, California, Connecticut, District of Columbia, Maryland, **Massachusetts**, New York, and Puerto Rico
Health Care Innovation Awards	Mayo Clinic	MA	Participant operating in **Massachusetts**, Minnesota, New York, and Oklahoma
State Innovation Models Initiative: Model Testing Awards	State of **Massachusetts**	MA	Model Testing Award states are implementing, testing and evaluating multi-payer health system transformation models. Visit the Model Testing Awards page for details on this state's effort

Massachusetts facilities where Innovation Models are being tested

Model Name	Organization Name	Address	City	State	Notes
Advance Payment ACO Model	Harbor Medical Associates PC	541 Main Street	Weymouth	MA	Operating in counties of Norfolk and Plymouth
BPCI Initiative: Model 2	Quincy Medical Center, A Steward Family Hospital, Inc.	114 Whitwell St	Quincy	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	Norwood Hospital, A Steward Family Hospital, Inc.	800 Washington St	Norwood	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	Good Samaritan Medical Center, A Steward Family Hospital, Inc.	235 Pearl St	Brockton	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	St. Elizabeth's Medical Center of Boston, A Steward Family Hospital, Inc.	736 Cambridge St	Boston	MA	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc

BPCI Initiative: Model 2	Nashoba Valley Medical Center, A Steward Family Hospital, Inc.	200 Groton Rd	Ayer	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	Morton Hospital, A Steward Family Hospital, Inc.	88 Washington St	Taunton	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	Merrimack Valley Hospital, A Steward Family Hospital, Inc.	140 Lincoln Ave	Haverhill	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	Carney Hospital, A Steward Family Hospital, Inc.	2100 Dorchester Ave	Dorchester	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	Tufts Medical Center	800 Washington St	Boston	MA	Number of Episodes: 48 // Convening Organization: Estes Park Institute, at Horty, Springer & Mattern

BPCI Initiative: Model 2	Baystate Medical Center	759 Chestnut St	Springfield	MA	Number of Episodes: 2 // Convening Organization(s): Premier, Inc.
BPCI Initiative: Model 2	St. Anne's Hospital Corporation	795 Middle St	Fall River	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	Holy Family Hospital, A Steward Family Hospital, Inc.	70 East St	Methuen	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 2	Harrington Memorial Hospital	100 South St	Southbridge	MA	Number of Episodes: 3
BPCI Initiative: Model 2	Lahey	40 Mall Rd	Burlington	MA	Number of Episodes: 3 // Convening Organization(s): Geisinger Clinic
BPCI Initiative: Model 3	Overlook Visiting Nurse Association	416 Belmont St	Worcester	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC

BPCI Initiative: Model 3	VNA Care Network, Inc.	120 Thomas St	Worcester	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
BPCI Initiative: Model 3	Overlook Visiting Nurse Association	41 State Rd	Dartmouth	MA	Number of Episodes: 48 // Convening Organization(s): Remedy BPCI Partners, LLC
Community-based Care Transitions Program	Elder Services of the Merrimack Valley, Inc.		Lawrence	MA	Operating in Massachusetts counties of Essex and Middlesex; New Hampshire counties of Hillsborough and Rockingham
Community-based Care Transitions Program	Elder Services of Worcester, Massachusetts		Worcester	MA	Operating in counties of Hampden, Hampshire, Middlesex, Norfolk, and Worcester
Community-based Care Transitions Program	Somerville-Cambridge Elder Services		Somerville	MA	Operating in Middlesex County

Community-based Care Transitions Program	Elder Services of Berkshire County		Pittsfield	MA	Operating in Berkshire County
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Community Health Connections, Inc. Fitchburg	275 Nichols Rd	Fitchburg	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Forest Park Clinic	532 Sumner Ave	Springfield	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Greater Gardner Community Health Center	175 Connors St	Gardner	MA	Not Applicable

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Harbor Health Services- Geiger Gibson Health Center	240 Mount Vernon St	Dorchester	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Harbor Health Services-Mid Upper Cape Community Health Center	30 Elm Ave	Hyannis	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Holyoke Health Center	230 Maple St	Holyoke	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Hilltown CHC	58 Old North Rd	Worthington	MA	Not Applicable

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Manet Community Health Center	1193 Sea St	Quincy	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Lowell Community Health Center @ 161	161 Jackson Street	Lowell	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Lowell Community Health Center - Metta Health Center	135 Jackson St	Lowell	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Manet Community Health Center	114 Whitwell St	Quincy	MA	Not Applicable

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Manet Community Health Center	180 George Washington Blvd	Hull	MA	Not Applicable
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	Manet Community Health Center	110 Squantum St	Quincy	MA	Not Applicable
Independence at Home Demonstration	Boston Medical Center		Boston	MA	Not Applicable
Innovation Advisors Program	Clay Ackerly MD, MS	165 Cambridge St	Boston	MA	Not Applicable
Innovation Advisors Program	Judith Rabig RN, PhD	222 River Road	Leeds	MA	Not Applicable
Innovation Advisors Program	Randi Berkowitz MD	1200 Centre Street	Roslindale	MA	Not Applicable
Innovation Advisors Program	Barbara Blakeney BSN, MSN	275 Cambridge Street	Boston	MA	Not Applicable

Innovation Advisors Program	Winnie Suen MD, MSc, LMT	88 Newton Street Robinson 2	Boston	MA	Not Applicable
Pioneer ACO	Beth Israel Deaconess Physician Organization	400 Blue Hill Drive	Westwood	MA	Operating in Eastern Massachusetts
Pioneer ACO	Partners Healthcare	115 Fourth Avenue	Needham	MA	Operating in Eastern Massachusetts
Pioneer ACO	Atrius Health	275 Grove Street	Newton	MA	Operating in Eastern and Central Massachusetts
Pioneer ACO	Mount Auburn Cambridge Independent Practice Association (MACIPA)	1380 Soldiers Field Road	Boston	MA	Operating in Eastern Massachusetts
Pioneer ACO	Steward Healthcare Network, Inc	500 Boylston Street	Boston	MA	Operating in Eastern Massachusetts

F. AHRQ Definition of a Patient Centered Medical Home

The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.

The medical home encompasses **five functions and attributes**:

1. Comprehensive Care

The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.

2. Patient-Centered

The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.

3. Coordinated Care

The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

4. Accessible Services

The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to patients' preferences regarding access.

5. Quality and Safety

The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

AHRQ recognizes the central role of health IT in successfully operationalizing and implementing the key features of the medical home. Additionally, AHRQ notes that building a primary care delivery platform that the Nation can rely on for accessible, affordable, and high-quality health care will require significant workforce development and fundamental payment reform.

Medical Homes in Current Towns Served by ANS:

Town	PCMH Practice
Acton	Acton Medical Associates
Boxborough	
Carlisle	
Chelmsford	Drum Hill Primary Care, LLC
Concord	Harvard Vanguard Med Assoc
Littleton	
Maynard	
Stow	
Sudbury	
Westford	
Unknown	

Medical Homes in Surrounding Towns:

Town	PCMH Practice
Arlington	Family Practice Group, PC
Framingham	VHS SVS Inc. Metro West Physicians Services-Cochituate
	Vanguard health System-New England-Metro West Physicians Services-Dr Rasmussen
Lowell	Lowell Community Health Center - Metta Health Center
	Lowell Community Health Center @161
	NEQCA-ECW1-O'Brien
Waltham	Joseph M. Smith Community Health Center

G. Basic Statistics about Home Care

The National Association for Home Care publishes statistics about home care in the US. The 2012 report can be accessed at: http://www.nahc.org/assets/1/7/10HC_Stats.pdf

H. EMS Considering Expanding Scope of Practice to Home Care

A new trend that is sweeping across many states is also seeking a foothold in Massachusetts. Emergency Medical Services personnel are working to expand their scope of practice. In a model of care they are calling community paramedicine, these personnel would be trained to perform an expanded role within to include such things as drug compliance monitoring, dressing changes and patient education around such issues as falls risk. Many states, particularly rural ones, have already moved to incorporate this new model of care. For example:

- Minnesota passed legislation in 2011 that formally recognized community paramedics as a distinct provider, and clarified their educational and training requirements.
- In 2012, Maine lawmakers removed regulatory barriers by authorizing up to 12 pilot programs.
- In Colorado, the state EMS office is developing a new regulatory framework that provides oversight through a conditional license, similar to that of home care, for community paramedics

New Hampshire paramedics are seeking a similar expansion to their scope of practice
According to the Boston Globe at least one pilot program between EasCare and Commonwealth Care Alliance is seeking approval from the state Department of Public Health. In a statement in response to the Globe, HCA said in part:
"Home health care providers are sensitive to and supportive of efforts that will reduce the need for patients to be hospitalized and rehospitalized. However, the problems associated with these patients getting good preventive care, post-acute care and chronic illness management support are not related to the availability of quality home based care. Rather, the main hurdles are insurance restrictions such as those that that say patients' needs must be skilled and not related to chronic illness in order to be covered. They also relate to a misunderstanding of home care coverage rules, which, in many cases, can lead to under-referring for those who may be qualified for covered care."
Source: http://www.bostonglobe.com/business/2014/05/30/paramedics-branch-into-home-care/WIBIbjRuBx6mQCeoNb3c3K/story.html

Other State m-health legislation can be found at:

http://www.patriotledger.com/article/20140512/News/140519422/?Start=1

I. Meriden CT 2012 – 2013 Annual Report

http://www.cityofmeriden.org/Customer-Content/WWW/CMS/files/MDHHS_Annual_Report_2012-13.pdf